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National Family Planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan

Study Report

National Family Planning Behavioral Study on the Use and Non-use of Contraceptives in Afghanistan

31 May 2017

DISCLAIMER

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CONTENTS

| | |
|--|-----------|
| ACRONYMS AND ABBREVIATIONS | IV |
| ACKNOWLEDGEMENTS | V |
| EXECUTIVE SUMMARY | VI |
| INTRODUCTION..... | 1 |
| 1.1 GENERAL SOCIO-POLITICAL AND DEVELOPMENT CONTEXT | 1 |
| 1.2 HEALTH SYSTEM OVERVIEW..... | 2 |
| 1.3 RMNCH SYSTEM AND PROGRESS..... | 3 |
| STUDY APPROACH..... | 5 |
| 2.1 METHODOLOGY..... | 6 |
| 2.1.1 Study Population..... | 6 |
| 2.1.2 Study Area | 6 |
| 2.1.3 Sampling and Sample Size..... | 6 |
| 2.1.4 Recruitment of Study Population | 7 |
| 2.1.5 Data Collection Approaches/Procedures..... | 10 |
| 2.2 DATA PROCESSING AND ANALYSIS..... | 10 |
| 2.3 ETHICAL CONSIDERATION | 11 |
| 2.4 QUALITY ASSURANCE | 11 |
| 2.5 STUDY LIMITATIONS..... | 11 |
| STUDY RESULTS..... | 13 |
| 3.1 OBJECTIVE 1: FACTORS AT INDIVIDUAL, COUPLE AND FAMILY LEVEL | 16 |
| 3.1.1 Couple relationship and their communication on child bearing..... | 17 |
| 3.1.2 Relationship between the couple and parents of the husband | 19 |
| 3.1.3 Family level planning for child bearing and birth spacing..... | 23 |
| 3.1.4 Personal perceptions of Islamic teaching on childbearing and birth spacing..... | 30 |
| 3.1.5 Awareness and knowledge about modern contraceptives | 33 |
| 3.1.6 Couple experiences of using modern contraceptives..... | 44 |
| 3.1.7 The unique impact of social networking..... | 54 |
| 3.2 OBJECTIVE 2: FACTORS AT SERVICE DELIVERY LEVEL..... | 57 |
| 3.2.1 Provision of information and counselling on birth spacing and family planning | 58 |
| 3.2.2 Provision of integrated birth spacing services at community and households level..... | 60 |
| 3.2.3 Provision of integrated birth spacing services in primary health care facilities | 62 |
| 3.2.4 The unique role of private pharmacies in provision of birth spacing methods | 66 |
| 3.2.5 Population and development planning and management | 68 |
| 3.3 OBJECTIVE 3: SOCIO-CULTURAL, RELIGIOUS AND POLICY FACTORS..... | 74 |
| 3.3.1 Socio-cultural factors influencing use of modern contraceptives | 74 |

| | |
|--|-----------|
| 3.3.2 Religious factors influencing use of modern contraceptives | 78 |
| 3.3.3 Policy factors influencing use of modern contraceptives..... | 85 |
| CONCLUSIONS AND RECOMMENDATIONS | 88 |
| 4.0 STUDY CONCLUSIONS AND RECOMMENDATIONS | 88 |
| 4.1 STUDY CONCLUSIONS..... | 88 |
| 4.2 STUDY RECOMMENDATIONS..... | 91 |
| 4.2.1 Recommendations for Operational and Mid-level Action | 91 |
| 4.2.3 Recommendations for National Level Action | 93 |

LIST OF TABLES

| | |
|--|----|
| Table 1: Provincial Categories Based on CPR | 7 |
| Table 2: Provincial Distribution Based on National CPR | 7 |
| Table 3: Illustrative data gaps in current measurement and reporting systems | 73 |

LIST OF FIGURES

| | |
|---|----|
| Figure 1: Socio-Ecological Model: Determinants of FP Use | 5 |
| Figure 2: Sampling Diagram for Family Planning Behavior Study..... | 9 |
| Figure 3: Current mix of methods in use..... | 14 |
| Figure 4: Mix of methods previously used by current non-users | 15 |
| Figure 5: Methods most favoured by CHWs..... | 16 |
| Figure 6: Perceptions on ideal FP information source for young people | 42 |
| Figure 7: Decision-making flow chart on family planning use | 45 |

Acronyms and Abbreviations

| | |
|-------|---|
| AfDHS | Afghanistan Demographic and Health Survey |
| AMS | Afghanistan Mortality Survey |
| BCC | Behavior Change Communication |
| BPHS | Basic Package of Health Services |
| CBHC | Community Base Health Care |
| CPR | Contraceptive Prevalence Rate |
| CSO | Central Statistical Organization |
| CHW | Community Health Worker |
| EPHS | Essential Package of Hospital Services |
| FGD | Focus Group Discussion |
| FHAGs | Family Health Action Groups |
| FPBS | Family Planning Behavioral Study |
| IDI | In-Depth Interview |
| KII | Key Informants Interview |
| MoPH | Ministry of Public Health |
| NGO | Non-Governmental Organization |
| RH | Reproductive Health |
| TFR | Total Fertility Rates |
| UNFPA | United Nation Population Fund |
| WHO | World Health Organization |

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Executive Summary

An exploratory qualitative study, the national Family Planning Behavioral Study (FPBS), was conducted to identify factors that influence use of modern birth spacing methods and to identify ways to mitigate or alter those influencers at the individual, couple/family, service accessibility, socio-cultural and policy environment for improvement of Contraceptive Prevalence Rate (CPR) in Afghanistan.

Constructs from socio-ecological model, health belief model and theory of planned behavior were used to develop the conceptual framework for the study. The constructs were arranged in four different levels: (1) individual level, (2) couple & family level, (3) service accessibility level, and (4) socio-cultural and policy environment level.

Focus Group Discussions (FGD), In-depth Interviews (IDI) and Key Informant Interviews (KII) were used to collect data from nine distinct target groups residing in the ten purposely-selected provinces: Kabul, Herat, Kandahar, Bamyan, Khost, Jawzjan, Kunar, Badghis, Badakhshan, and Samangan. The main study findings are presented below into four main section based on the four levels of the study conceptual framework.

Individual Level Findings:

- ◆ **Self-efficacy perception:** A strong sense of confidence in their ability to manage their child bearing and birth spacing was reported by many among the current or experienced users of contraceptives, while many among the non-users reflect greater dependence on other people and on Allah as the determinants of child bearing, birth spacing and family size.
- ◆ **Perceived religious norms and values:** Many users reported perceived religious norms that support use of family planning methods for managing the spacing of births. For example, methods are used to obey the Islamic principle of “two years breastfeeding” of the child. Some of the users acknowledged religious norms and values that discourage use of contraceptives, but reported personal (e.g., illness), family (e.g., burden of care for the children) and economic (e.g., limited resources to meet all the needs of the children) as factors that encourage them to use the methods. Many among the non-users reported consideration of religious norms as a major reason for not using the methods.

- ◆ ***Perceived social and economic value attached to childbearing:*** Both users and non-users reported a desire for large family size with a strong preference towards boys. The desired family size reported by the non-users is larger (more than 6 children) as compared to desired family size reported by the users (less than 6 children). Number of children, especially number of male children, is reported as an indicator of strength and "good fortune" of a couple.
- ◆ ***Perceived transition in value attached to family size:*** Many respondents (especially in the provinces of Herat, Kabul and Bamyan) acknowledge a trend of change in social perceptions and norms about family size and use of birth spacing methods, from preference of large family size based on uncontrolled child bearing to one's natural potential, to having fewer children through use of birth spacing methods. This is mainly attributed to: a) Increased availability of health services that has resulted in greater awareness about and utilization of birth spacing methods; b) Education and other forms of exposure (e.g., moving from rural to urban areas, migration to other countries, etc.); and c) Age-based difference in perceptions of young adults compare to the older generation (parents, grandparents, etc.).
- ◆ ***Life experiences and beliefs of close family members:*** mostly mother-in-law and mother of the woman were reported to be influential in determining the desired family size, besides the couple's perceived fertility norms. For example, a mother or mother-in-law, who herself had a smaller family (just one male child), is reported to be encouraging the couple for a larger family size, while mother-in-law with a larger family size, who have not experienced any negative consequences, was also encouraging the couple to replicate her model of family size.
- ◆ ***Knowledge about methods:*** (available types, dose, potential side effects, and coping strategies to tackle potential side effects) was not optimum among users and non-users. Most of the users had some knowledge about the method that they were currently using (e.g., on dose, potential side effects); and were able to name a few other available methods. Most of the users reported switching to another method as a strategy to cope with potential side effects of the method. Some of the respondents not currently using methods were knowledgeable about methods, based on previous use experience. However, many of the non-users had limited or no knowledge about important details such as method dosing, possible side effects and the right action to take when such side effects occur.
- ◆ ***Familiar and frequently used methods:*** Pills, Condoms and Injections were most frequently named methods. However, many among all respondent categories were not able to name the long acting methods (IUD, Implant, TL and Vasectomy). Many among the female users were not comfortable to name condom as a planning

method, when asked to identify some of the family planning methods. Condoms were identified as "this", "the thing" and "it" by most of the female users. However, male users were able to identify and name condoms without a great amount of hesitation.

- ◆ **Perceived side effects:** Most of the issues discussed by respondents that reflect knowledge of birth spacing methods were on problems experienced or feared in relation to the use of different methods, and less about the benefits. Most of the concerns focused on: reduced ability to perform regular tasks (e.g., IUD use and lifting of weights, implant and ability to use the arm where it is inserted); effect on menstruation (e.g., regularity of cycle, volume and duration of periods); and health complications as a result of using some methods, which may require specialized and often very expensive treatment. Identified areas of misinformation in this respect were appropriately addressed in the study process, through explanations by the study field teams and referral to health facilities.
- ◆ **Cues for action:** Client identification card, tablets' blister packet and close friend reminders were reported as cues for obtaining the next dose of a method.
- ◆ **Participation in social networks:** Most of users have reported about the presence of informal "users networks," in which the users share their knowledge and experiences about the methods with one another, and often go together to obtain the next dose of the method. Similarly, social network were noted as important in demotivating method use, especially when they involve non-users and users who have experienced problems and stopped use.
- ◆ **Perceived benefits from method use:** The dominant ideas expressed by respondents in this respect were related to better health of children, and good life experience for mothers and all other family members because of the less pressure and struggle experienced in providing care and support for the children.

Couple and Family Level Findings:

- ◆ **Family-level Planning for child bearing and birth spacing:** was a common experience as a process that involves the husband, wife, parents and other members in both families; mostly as a response to: a) the number of children a couple already has; b) the perceived adequacy of boys among the children; and c) problems experienced in bearing and raising them. This planning is based on clear economic and development considerations at this micro-level. However, there is limited evidence that this has been strengthened and utilized by community transformation and economic development initiative of government and other actors. It is not clearly articulated and adequately promoted as an important element in family planning programs and services.

- ◆ **Couple communication:** Most of the user and non-user respondents indicate that consideration and decision-making about childbearing are based on discussion between the wife and husband within the context of the extended family unit. Use of the methods was more likely for couples with relatively open and male-led communication which results into a consensus method use and method choice.
- ◆ **Family influence on couple decision:** The parents of the husband (especially the mother), usually as the heads of the extended family setting in which young couples live, have a strong influence on childbearing and birth spacing decisions of the couple. Other women in the extended family (sisters of the husband, wives of the husband's brothers, mother and sisters of the wife, etc.) also influence the child bearing and child care decisions and arrangements of the couple.
- ◆ **Addressing difference in views between husband and wife:** Almost all the female users have reported about using the methods in line with the "permission" of the husband; and many non-users attribute this non-use to the denied permission by the husband. However, some women reported using family planning methods after getting approval of mother-in-law, as the husband was not willing to provide the consent for its use.

Service Level Findings:

- ◆ **Education and counselling on family planning methods:** Couple counseling is neither practiced nor perceived as a feasible family planning counseling approach by health workers working in public and private health care facilities. Counseling is conducted by female health workers (midwives, female doctors and female CHWs) with female clients visiting these health facilities or during home visits conducted by the female CHWs. Males who accompany their wives to obtain family planning methods from the public or private sector are most often not directly included in the counseling process. In a few cases, available male workers at health facilities or male CHWs provide such counseling for the male clients. The sources of family planning information noted as ideal for unmarried young people such as schools, Mosques, social media, etc., are currently underutilized; but there is keen and near universal support for their greater use.
- ◆ **Gender-based challenges in service provision and utilization:** In the public health sector, male health care providers are minimally involved in the provision of family planning services to their clients. At the health facility level family planning counseling and provision of family planning methods is considered as a duty specifically assigned to the midwife or female doctor. Absence of a midwife or female doctor from the health facility makes it almost impossible for the clients to obtain the needed family planning counseling and get the desired methods.

- ◆ ***Provider skills as a barrier to accessing specific methods:*** Inadequacy of the health care provider skills makes it difficult for the clients to obtain their desired methods. Midwives have not been mandated and trained to provide implants; some midwives have limited skills and confidence to insert IUD; and some of the CHW cannot give injectable methods.
- ◆ ***Choice between public and private sources of services:*** Public health sector facilities are mostly used as a primary source for getting family planning counselling and for obtaining methods, mainly because the services are free and the facilities are close or easily accessible. Some clients prefer the private sectors as the primary source of methods, for example those who use condoms, those living closer to a private source and far from the public health facility, and those that prefer the privacy and quick services in private sector. Private sector is also used as a secondary source of family planning methods at times of method stock out in the public sector.
- ◆ ***Adequacy of communication materials and job aides:*** Supply of family planning IEC materials is not systematic to public sectors and most of the newly developed family planning IEC materials were not present in public health facilities. IEC materials developed by MoPH are not supplied to private sector health facilities and lack of a channel of communication for obtaining the IEC materials from MoPH was reported by the private sector health facilities.

Socio-Cultural and Policy Environment Level Findings:

- ◆ ***Social and cultural norms on marriage and childbearing:*** The socio-cultural factors reported as influencing use of modern contraceptives include: early and arranged marriages as a continuation of the child bearing and family expansion aspirations of the parents of the couple; extended family living arrangements which allow for persistent social pressure and reinforcement for adherence to the child bearing views of elders and other family members; and strongly held social norms about child bearing and large family size.
- ◆ ***Religious instruction and values about child bearing and birth spacing:*** that were reported as influencing the use of modern contraceptives include: a) Islamic teaching about the family duty of childbearing and child instruction into the life and values of obedient Muslims; b) Conditional allowance of contraceptive use by Muslim families (e.g., to ensure and protect the health and wellbeing of the child or the mother); and prohibition of specific methods of contraception (especially permanent methods); and c) The mandate and ability of Mullahs to teach about childbearing, child care and

other family development undertakings. Most of the Mullah respondents indicate that they often speak about breastfeeding and other aspects of child nurture as part of their work in leading prayers and educating the people. However, fewer among them acknowledge speaking about birth spacing to the same measure, because of their inadequate awareness and knowledge on this; and the fact that many people do not consult the Mullahs on the subject.

- ◆ **Policy support for family planning:** The national Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) strategy includes appropriate emphasis on family planning as a core service area. However, there is currently no comprehensive and costed implementation plan for the country, to enable sustained delivery of family planning services to all married couples.
- ◆ **Health sector leadership on family planning:** The family planning unit within MoPH has a narrow institutional mandate and scope and limited human and material resources for the necessary coordination of the different actors in family planning in the health sector (e.g., private sector services, reproductive health service actors, health promotion and health education, etc.). Some of the NGOs contracted to manage implementation of BPHS are not specifically attuned to family planning services as an essential element in health care, and thus lack capacity for effective integration of such services in the work they manage.

Therefore, it is recommended to:

1. Develop a costed implementation plan for the national RMNCAH strategy.
2. Strengthen the family planning unit within the MoPH by expanding its scope and provision of needed resources so that it can become a fully functional entity within the MoPH.
3. Improve the use of mass media for increasing demand for family planning services.
4. Work with MoHE on improving the curricula in health training institutions for doctors, midwives, nurses, etc., so that all new graduates have the required skills and knowledge about all relevant family planning methods.
5. Advocate for inclusion of family planning in the high school curricula.

6. Enhance partnership with MoHRA for greater involvement of religious leaders for promoting family planning among masses.
7. Improve the involvement of male care provider in the family planning services at health facility level by revising the job descriptions, provision of needed trainings and proper monitoring of male providers' involvement in the provision of the family planning services to the clients.
8. Enhance the skills of midwives and CHWs for proper administration of the family planning methods including long-acting reversible methods.
9. Improve family planning commodity stock outs in public sector by establishing a mobile technology based stock management system and timely provision of the family planning supplies.
10. Establish a system for enabling the private health care providers to provide quality family planning services by training, support supervision, supply of needed IEC materials, etc.
11. Design communication strategies to promote couple communication based on mutual respect and equality, and to promote early couple communication on child bearing and birth spacing as an element in pre-marriage counselling.
12. Design capacity building strategies to improve counseling skills of the health care providers so that clients are properly counseled on method choice and effective use, and on management of problems associated with method use.
13. Design social network interventions to promote the use of family planning methods and enhance participation of women and men with experience using contraceptives as FP communicators.
14. Design communication strategies to manage the rumors about family planning methods and to promote the use of long acting family planning methods.



Introduction

The National Family Planning Behavioral Study (FPBS) on the use and non-use of contraceptives examines the situation of married women in Afghanistan who use modern contraceptive methods and compares this to the situation of married women who do not, in order to understand how and why women take action to use family planning. The research aims to discover if certain elements in social and family relationships influence the decision to use family planning or not. The study explores the relative importance of elements that affect the use of modern family planning methods from the perspectives of user/non-user married women, user/non-user men, mother in laws, religious leaders and service providers who offer family planning methods. The study is implemented by the Ministry of Public Health (MoPH), with support from the United Nations Fund for Population Activities (UNFPA) and the United States Agency for International Development (USAID).

The MoPH is aiming to increase availability of high quality family planning services and ensure women and men have access to quality family planning services. Similarly, UNFPA Afghanistan supports the Ministry of Public Health to take steps to meet the family-planning needs and to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice. Meanwhile, as the world's largest family planning bilateral donor, USAID is committed to helping countries meet the family planning and reproductive health needs of their people. USAID advances and supports voluntary family planning and reproductive health programs in nearly 40 countries including Afghanistan.¹

¹ The U.S. Agency for International Development (USAID). USAID. 16 December 2016. 22 December 2016 <<https://www.usaid.gov/what-we-do/global-health/family-planning>>.

1.1 General socio-political and development context

Women have experienced tremendous upheaval throughout the history of Afghanistan and have been forced to bear the brunt of over three decades of conflict and insecurity. Women's human rights deteriorated to unprecedented levels during the conflicts and war as they were denied their basic rights, including access to education, healthcare, and employment. After the collapse of the Taliban regime, women made a number of gains. Nevertheless, much remains to be done to realize women's full and equal rights.

The women still remain to a large extent excluded from social and political life, and decision-making pertaining to their own security and well-being. Women are vulnerable to sexual violence including: rape, sexual harassment and forced marriages. In remote areas, women lack access to justices as a result of the armed conflict and the marginalization of women in society at large. They lack proper access to healthcare services, education, and employment opportunities as a result, illiteracy and unemployment rates are highest among women, and Afghanistan suffers from a significant maternal mortality rate. Internally displaced women and men living in conflict-affected communities are particularly vulnerable to insecurity.²

Afghanistan with a projected population of 27.5 million people; has one of the highest total fertility rates (TFR) higher than 5.3.³ Because of relatively high fertility in the past, nearly half of Afghanistan's population (47 percent) is under age 15 years, and 16 percent is under age 5 years.⁴ Likewise, high fertility and related factors such as short birth intervals are associated with increased risk of maternal and child mortality.⁵ Yet, the population will continue to grow for in the coming decades. One of the significant indicators of high fertility rate and rapid population growth is the high proportion of married women with unmet need for family planning; reported at 25% among currently married women in the 2015 AfDHS.

1.2 Health system overview

Afghanistan's health sector made significant progress over the last decade, which translated in substantial decline in infant, child and maternal mortality. The concerted efforts have enabled Afghanistan to stay on track in achieving MDGs 4 and 5. However the baseline indicators were extremely poor and until now remain high in regional and global comparison⁶. The Countdown 2015 report for Afghanistan indicates that between 2005

2 Ministry of Foreign Affairs. «AFGHANISTAN'S NATIONAL ACTION PLAN ON UNSCR 1325-WOMEN, PEACE, AND SECURITY.» 2015.

3 Ministry of Public Health, Central Statistics Organization, ICF International. «Afghanistan Demographic and Health Survey 2015: Key Indicators Report.» 2016.

4 Ministry of Public Health . «Afghanistan Mortality Survey.» 2010.

5 Ibid.

6 World Health Organization (WHO). «country cooperation strategy.» http://www.who.int/countryfocus/cooperation_strategy/ccs-brief_afg_en.pdf. 02 12 2015.

and 2013, the number of deployed facility and community-based health-care professionals also increased, including for nurses (738 to 5,766), midwives (211 to 3,333), general physicians (403 to 5,990), and community health workers (2,682 to 28,837)⁷.

Between 2003 and 2015, Afghanistan experienced a 29% decline in mortality of children younger than 5 years. Childhood vaccination coverage rates for the basic vaccines from the Expanded Programme of Immunization (e.g., BCG, measles, diphtheria-tetanus-pertussis, and three doses of polio) doubled over this period (about 40% to about 80%).⁸

Although definite reductions in maternal mortality remain uncertain, concurrent improvements in essential maternal health interventions suggest parallel survival gains for mothers. In a little over a decade (2003–13 inclusive), coverage of several maternal care interventions increased, e.g., for antenatal care (16% to 53%), skilled birth attendance (14% to 46%), and births in a health facility (13% to 39%). Multivariable analysis of factors contributing to overall changes in skilled birth attendance and facility births suggests independent contributions of maternal literacy, deployment of community midwives, and proximity to a facility.⁹

Despite conflict and poverty, Afghanistan has made reasonable progress in its reproductive, maternal, newborn, and child health indicators over the last decade based on contributions of factors within and outside the health sector. However, equitable access to health care remains a challenge and present delivery models have high transactional costs, affecting sustainability.¹⁰

1.3 RMNCH system and progress

The Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. The knowledge of family planning methods is an important precursor to use. According to AMS 2010, about 91.6 percent of women of 15–49 ages have knowledge about any modern family planning method, but only 20 percent of women reported to use any modern method of family planning¹¹ suggesting a huge gap between knowledge and practice of family planning methods. Similar figure (19.8 Percent) of family planning use was reported by AfDHS 2015.¹²

7 N. Akseer, Salehi A., Moazzem-Hossain S., Mashal M., Rasooly M., Bhatti Z., Rizvi A., Bhutta Z. (2016) Achieving maternal and child health gains in Afghanistan: a Countdown to 2015 country case study Lancet Glob Health 2016; 4: e395–413

8 N. Akseer, Salehi A., Moazzem-Hossain S., Mashal M., Rasooly M., Bhatti Z., Rizvi A., Bhutta Z. (2016) Achieving maternal and child health gains in Afghanistan: a Countdown to 2015 country case study Lancet Glob Health 2016; 4: e395–413

9 N. Akseer, Salehi A., Moazzem-Hossain S., Mashal M., Rasooly M., Bhatti Z., Rizvi A., Bhutta Z. (2016) Achieving maternal and child health gains in Afghanistan: a Countdown to 2015 country case study Lancet Glob Health 2016; 4: e395–413

10 N. Akseer, Salehi A., Moazzem-Hossain S., Mashal M., Rasooly M., Bhatti Z., Rizvi A., Bhutta Z. (2016) Achieving maternal and child health gains in Afghanistan: a Countdown to 2015 country case study Lancet Glob Health 2016; 4: e395–413

11 Ibid.

12 Ministry of Public Health, Central Statistics Organization, ICF International. «Afghanistan Demographic and Health Survey 2015:Key Indicators Report.» 2016.

Among those women who do use contraception, the most popular method is use of injectables (7 percent) followed by the pill (5 percent).^{13,14} As indicated by AfDHS 2015, the contraceptive prevalence rate (CPR) is higher among married women in the urban areas than women in the rural areas (35 percent and 19 percent, respectively).¹⁵

The highest prevalence of contraception use is observed among married women aged 35-39 (29 percent), compared to 8 percent of married women aged 15-19 years, indicating that the contraceptive prevalence rate (CPR) among married women increases with age.¹⁶

There has been a marked increase in the use of a contraceptive method among currently married women with the increase more rapid between 2003 and 2006 than in the more recent years.¹⁷ This is while the comparison of figures reported on the modern contraceptive use by AMS-2010 (20 percent) and AfDHS-2015 (19.8 Percent) indicates no improvement in the CPR in the past five years.

The 2015 Comprehensive Family Planning Needs Assessment (CFPNA) in Afghanistan identified key health system gaps were 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.¹⁸

13 Ministry of Public Health . «Afghanistan Mortality Survey.» 2010.

14 Ministry of Public Health, Central Statistics Organization, ICF International. «Afghanistan Demographic and Health Survey 2015:Key Indicators Report.» 2016.

15 Ministry of Public Health, Central Statistics Organization, ICF International. «Afghanistan Demographic and Health Survey 2015:Key Indicators Report.» 2016.

16 Ministry of Public Health, Central Statistics Organization, ICF International. «Afghanistan Demographic and Health Survey 2015:Key Indicators Report.» 2016.

17 Ministry of Public Health . «Afghanistan Mortality Survey.» 2010.

18 United Nations Population Fund (UNFPA). «A Comprehensive Family Planning Need Assessment in the Islamic Republic of Afghanistan.» January 2016.

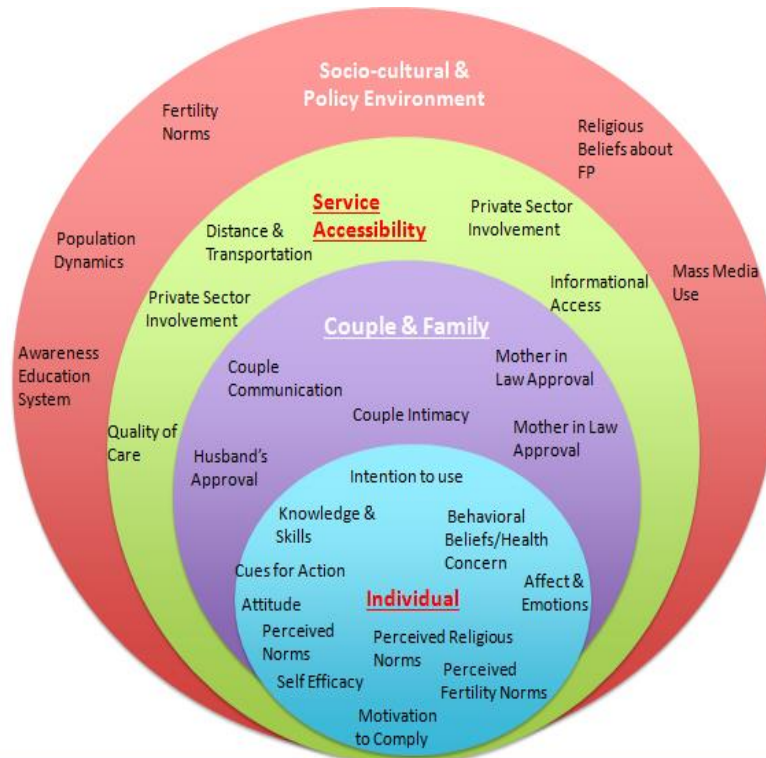


2

Study Approach

The use and non-use of contraceptives is influenced by a wider range of supply and demand side factors. This study is informed by socio-ecological model as conceptual and theoretical framework. The socio-ecological model is used to provide comprehensive frameworks for understanding of the multiple and interacting determinants of behaviours. The core concept of a socio-ecological model is that: behaviour has multiple levels of influences, often including individual, interpersonal, organizational, community, and public policy. For the purpose of this study, the socio-ecological model was adjusted in four main levels of determinants influencing the use and non-use of family planning. These four levels include: individual, couple & family, service accessibility, and socio-cultural & policy environment; as illustrated in Figure 1. At each level factors that influence the use non-use of family planning were identified, reviewed, and assessed.

Figure 1: Socio-Ecological Model: Determinants of FP Use



A. Individual Level

At this level, personal factors such as intention to use, knowledge & skills, cues for action, attitude, perceived norms, self-efficacy, behavioural beliefs/ health concerns, affect & emotions perceived religious norms, perceived fertility norms, motivation to comply that influence the family planning use and non-use are reviewed and assessed.

B. Couple & Family Level

At this level, couple and family level factors such as couple communication, couple intimacy, relationship satisfaction, husband's approval, and mother in law approval, which influence the family planning use and non-use are reviewed and assessed

C. Service Accessibility Level

At this level, services accessibility level factors such as distance & transportation, cost, quality of care, private sector involvement, informational access, and coordination between components of health system, which influence the family planning use and non-use are reviewed and assessed.

D. Socio-cultural & Policy Environment Level:

At this level, socio-cultural & policy environment level factors such as fertility norms, religious beliefs about family planning, population dynamics awareness, education system, and mass media use, which influence the family planning use and non-use are reviewed and assessed.

2.1 Methodology

An exploratory qualitative study was used to obtain in-depth knowledge about the family planning use and non-use. Qualitative data collection techniques such as Focus Group Discussions (FGDs), in-depth Interview (IDIs) and KIIs were used as excellent data collection technique for this study.

2.1.1 Study Population

- ◆ The target study population included:
- ◆ User/non-user women aged 15-49 yrs
- ◆ Husbands user/ and non-users
- ◆ Mother in law
- ◆ Community Health workers (CHWs) both male and female
- ◆ Family Health Action Groups (FHAGs)
- ◆ Religious Scholars
- ◆ Midwives and pharmacists at public health facilities
- ◆ Female doctors/gynecologists and pharmacists in private sector
- ◆ Program and Policy level people including MoPH, PPHD (RH, CBHC), Implementing Partners (RH, CBHC)

2.1.2 Study Area

This study was conducted in ten purposely-selected provinces namely Kabul, Herat, Kandahar, Bamyan, Khost, Jawzjan, Kunar, Badghis, Badakhshan, and Samangan. The selection of provinces is done, based on the contraceptive prevalence rate (CPR) reported in Afghanistan Demographic and Health Survey, 2015.

2.1.3 Sampling and Sample Size

In order to select target provinces, all 34 provinces were arranged in descending order based on the contraceptive prevalence rate (CPR) reported in Afghanistan Demographic and Health Survey (AfDHS 2015). Then, the 34 provinces were grouped into four distinct groups: the first group consists of the provinces with a CPR higher than the national average (23%); the second group consists of the provinces with a CPR which is below national average but is greater than 15%; the third group consists of the provinces with a CPR between 15% and 10%; and all the provinces with a CPR below 10% were lumped into the fourth group (see table. 1).

Table 1: Provincial Categories Based on CPR

| Provincial Categories | First group | Second Group | Third Group | Fourth Group |
|-----------------------|-------------|--------------|-------------|--------------|
| CPR | >23% | >15% - 23% | 10% -15% | < 10% |

The following table depicts the provincial distribution in four categories, based on the Afghanistan Demographic and Health survey data on contraceptive prevalence rate (CPR).

Table 2: Provincial Distribution Based on National CPR

| Provincial Categories | | | | | | | |
|-----------------------|---------|--------------|---------|-------------|---------|--------------|---------|
| First group | | Second Group | | Third Group | | Fourth Group | |
| Province | CPR (%) | Province | CPR (%) | Province | CPR (%) | Province | CPR (%) |
| Herat | 60.5 | Bamyan | 21.9 | Jawzjan | 14.6 | Takhar | 9.4 |
| Logar | 32.8 | Nangarhar | 21.4 | Ghor | 14.6 | Badakhshan | 7.8 |
| Kabul | 32.1 | Balkh | 20.6 | Paktya | 14.5 | Kunarha | 6 |
| Wardak | 31.9 | Kapisa | 20.1 | Laghman | 14.4 | Samangan | 4.6 |
| Nimroz | 29.5 | Khost | 16.2 | Ghazni | 13.4 | Nooristan | 0.5 |
| Paktika | 28.9 | Baghlan | 15.6 | Badghis | 13.4 | | |
| Kandahar | 28.6 | Helmand | 15.5 | Kunduz | 12.9 | | |
| Parwan | 27.3 | | | Faryab | 12.4 | | |
| Farah | 27.3 | | | Panjsher | 12.2 | | |
| | | | | Sar-E-Pul | 11.8 | | |
| | | | | Urozgan | 11.8 | | |
| | | | | Daykundi | 11 | | |

Using a non-probability purposeful sampling, a total of 10 provinces were selected for the data collection. Initially, within each group a province with the highest CPR was selected for the data collection, that is Herat, Bamyan, Jawzjan and Badakhshan. Then, based on geographical and ethnic variability within each group one province was selected that is, Kandahar, Khost, Kunar and Samangan. Kabul and Badghis were added to the list of the selected provinces so that to enrich data regarding the use and non-use of the family planning is collected.

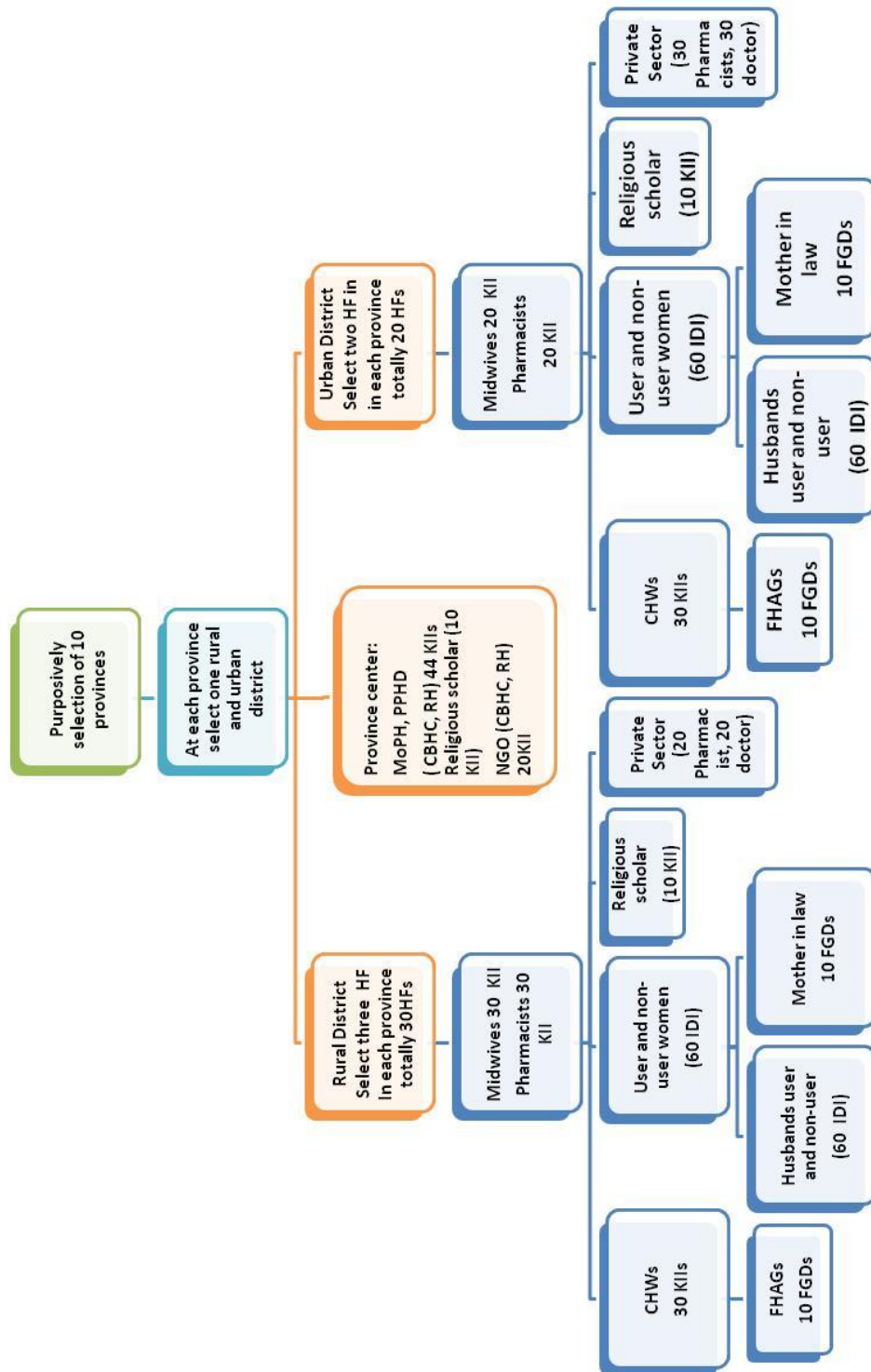
Then, based on the conceptual framework of the study the following target groups were selected for data collection: Users and Non-User Women, Husbands of Users and Non-Users, Religious leaders (Mullahs), Mother in Law, Family Health Action (FHA) groups members, CHWs, Pharmacy in charge of the public health facilities, midwives working in the public health facilities, doctors working in private clinics or hospitals, private pharmacies, and key program and policy people at national and provincial level. Data from the mentioned target population is collected using In-depth Interviews (IDIs), Focus Group Discussion (FGDs), and Key Informant Interviews (KIs).

2.1.4 Recruitment of Study Population

FGDs with mothers in law and members of FHAGs took place at the community level. In-depth interviews (IDIs) with study population and key informants interviews (KI) were conducted at provincial level, at the health facility or at the community level. Recruitment of health workers (midwives and pharmacists) of public sector was performed through the BPHS health facilities in study sites. Staff teams of NGOs implementing the BPHS and EPHS were approached for recruitment of health workers in the public facilities. Randomly selected health facilities were approached to complete the recruitment of midwives and pharmacists for KIs. Likewise, for the recruitment of CHWs, the support and facilitation of BPHS implementers and BPHS health facilities was used.

Majority of the IDIs with the user and non-user women and husbands were conducted in the catchment of HFs and CHWs in purposively selected urban and rural areas. Purposive sampling strategy was used to recruit target groups with preselected criteria. The KIs with religious scholars took place at urban and rural areas. The religious scholars were selected based on already defined selection criteria. The already identified program and policy level people were approached by research team members to complete the IDIs and KIs.

Figure 2: Sampling Diagram for Family Planning Behavior Study



2.1.5 Data Collection Approaches/Procedures

A. Focus Groups Discussion (FGD)

The FGD was used as one of the best data collection methods to obtain group opinion on the study subject. Considering the local culture, realities, and norms, the recruitment strategy will be developed and implemented. The FGDs were conducted with already identified target groups. The numbers of participants in each FGD were between eight to ten people with a maximum of 12 people. Ahead of starting the FGDs, informed consent was obtained. Two researchers or facilitators conducted the Focus groups. One person acted as the moderator of the discussion and the other acted as the note-taker. Each FGD lasted for at least one hour. Most of the FGDs were audio recorded.

B. In-depth interviews/ Key informants interviews

The IDIs/KIIs with individuals and key informants were conducted to elicit a vivid picture of the participant's perspective on the topic. IDIs/KIIs were conducted face-to-face and involve one interviewer and one participant. Considering the culture norms and field reality it needed two field staff, one interviewer and one note taker conducted the interview with participants. The participants for interview were recruited based on the set objectives and requirement of the study. Ahead of starting the interviews, the participants were informed about the voluntary nature of the interview. The anticipated risks and benefits of the study to the individual participant and the community were explained. Before asking any interview questions, informed consent in accordance with procedures specified for this study was obtained. The informed consent was oral, where needed; necessary written informed consents will be obtained. Interviews were conducted in a private location with no outsiders present and where people feel that their confidentiality is completely protected.

C. Data collection tools

Study instruments and data collection tools including consent form, FGD guides, IDI, KII guides were developed by the core research team in English and translated in to Dari and Pashto based on the need of study site. The study data collection tools were approved by the study steering committee and are attached in annex of the report.

2.2 Data processing and Analysis

Processing and analysis of all primary qualitative data was led by the study consultants, supported by a team of 16 Assistants. The main tasks of the Assistants included:

1. Data cleaning: review all translated data for completeness, coherence and internal logic; validate and edit/clean the data based on audio recordings and/or engagement with specific data collectors as may be necessary; labelling all pages of all data sets with unique identifiers.
2. Orientation to data coding using Atlas.ti: participated in a 3-day orientation session on Atlas.ti software and qualitative data coding using the software.
3. Data coding: work under the guidance of the study consultants to code all the data sets.

The data coding was based on the structure of the different data collection tools, and the issues discussed therein. All discussions questions in each tool were adopted as the primary codes. Secondary codes were developed based on the emerging themes in the responses to different discussion issues. Three coding tools that are in-built in Atlas.ti were used: a) Memos – of interpretation, linkage of ideas and reminders for deeper analysis; b) Quotes – labelling and classifying; and c) Concept mapping.

Content analysis was conducted as an iterative process with three main phases:

1. Pooling of all data in line with the applied codes and linked analysis of each code pool along the respective categories of respondents. For example, in a data pool on the theme of spouse influences on FP use or non-use, the analysis can delineate views given by user and non-user women, or view from men and women; or views from household-level respondents and service providers.
2. Interpretation of data based on statements made and their construction, tone or sentiment evident, context of the statement (e.g., group or individual settings, what is discussed before in the flow of data collection, etc.
3. Analysis of dominance – the more frequent concepts and categories, the contexts in which they dominate; etc. This may include a semi-quantified summarizing and interpretation of the data.

2.3 Ethical Consideration

The research protocol and study tools were submitted to Institutional Review Board (IRB) at MoPH for technical and ethical review and approval before the data collection process. The approval was obtained which is attached in annex of the report.

2.4 Quality Assurance

Specific efforts were made to ensure and maintain the quality of data collected, processed and analyzed under this study. The study team assured the quality of study at the designing stage, training stage, data collection stage, and analysis stage.

Core research teams were involved in developing of study tools, training of research team, and supervision of data collection process. Qualified researchers were hired and trained on qualitative interview and focus group facilitation. During training, trainees were trained on different aspects of qualitative research methods including in-depth interview and focus group discussion. They were provided with the opportunity to exercise data collection in the class environment through role-playing and simulations with other researchers and study staff, using the actual interview/FGD guides. Trainees also participated in a field exercises to apply their gained knowledge and skill. The researchers also practiced and conducted pilot interviews with people in the community who did not participate in the study.

The data were collected based on standard procedure developed by the core study team. In order to ensure quality of data collection in the field, regular supervision and monitoring of the data collection were ensured through field staff and research core team. Almost 80% of all the FGDs and IDIs, KIs were audio recorded and were used for verification purpose during transcription process and expanding the field notes.

To further ensure and maintain the quality of data for analysis, qualified researchers prepared the study transcript and translated it from local languages to English. The data were analyzed based on analysis protocol developed by core research team and agreed upon by steering committee.

2.5 Study limitations

- ◆ FHA Groups are not present in Kabul, therefore; FGDs of FHA Groups were not conducted. Also in Khost, two of the selected HFs did not have FHA Groups so interviews with them were not conducted.
- ◆ Interviews with CBHC officers of provincial public health directorate in Herat, Badakhshan, Kunar and Khost were not conducted as either was vacant or position was not present in organizational structure.
- ◆ Provincial RH Officer of Kabul and Khost were not conducted as the refused to be interviewed. (why was not conducted?)
- ◆ CBHC and RH officers of NGO implementing BPHS in Khost refused to participate in the interview.



Study Results

This section presents the study results, based on in-depth qualitative analysis of the primary data, semi-quantified analysis of selected indicators in the primary data, and triangulation with available relevant quantitative data and reviewed literature. This introduction to the section includes a synthesis of the key socio-demographic characteristics of the respondents, with focus on the aspects that may have a bearing on their views and practices with respect to birth spacing. The study results are then presented in three main parts, in line with the study objectives.

1. The factors influencing modern contraceptive use at the individual, couple & family level
2. The factors at service delivery level (public & private) influencing modern contraceptive use by married couples
3. The socio-cultural, religious & policy environment factors influencing modern contraceptive use by married couples

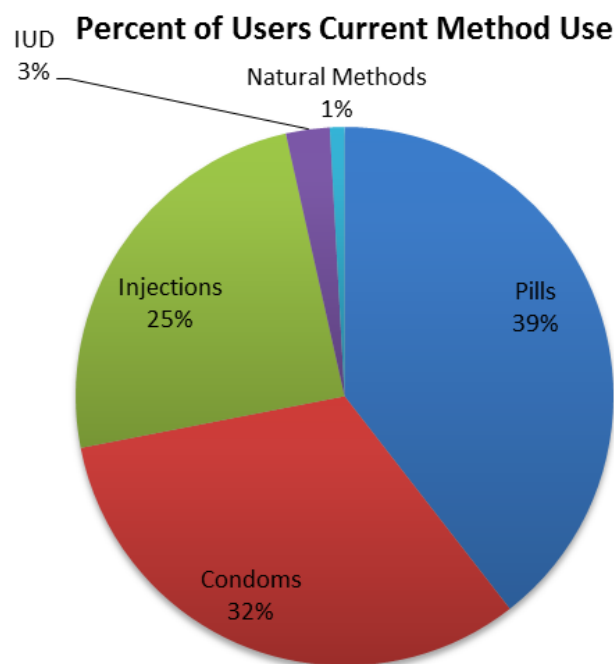
Users Profile:

Data from a total of the 118 users was collected. The average age of the users was 34 years with a standard deviation of 8 years. The youngest user was 19 years old while the oldest user was 55 years old. Users reported about having an average of 4.8 children, 2.5 of the children were boys while 2.3 of the children were girls. On average, users desired one more child than their average number of children; a desire for having an average of 5.9 children.

Awareness about long term methods, IUD, Implant, Tubal Ligation and Vasectomy, was very low among the users. Only 34% of the users reported about being aware of the IUD, 28% have reported being aware of the Implant, 16% have reported about being aware of Tubal Ligation, and 3% were aware of Vasectomy at the time of interview. The majority (80%) of the users reported not being aware of birth spacing methods before marriage. A large majority (97%) of the users favored the idea of inclusion of birth spacing related content in the school curriculum.

Users reported an average of 3.2 years as the ideal spacing period between two pregnancies. The majority (39%) of the users reported using oral contraceptive pills, 32% reported using condoms, and 25% reported using injection method. The chart below shows the use of the different contraceptive methods as reported by the users.

Figure 3: Current mix of methods in use



Non-users Profile:

Data from a total of 117 nonusers was collected. The average age of the non-users was 33 years with a standard deviation of the 7 years. The youngest non-user was 20 years old while the oldest was 60 years old. Non-users reported about having an average of 4.4 children, 2.1 of the children were boys while 2.3 of the children were girls. On average non-users desired two more children than their average number of children; a desire for having an average of 6.2 children.

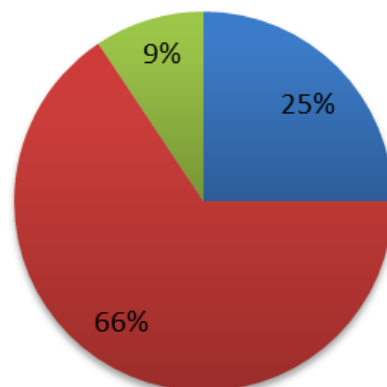
Awareness about long term methods, IUD, Implant, Tubal Ligation and Vasectomy was even lower among the non-users as compared to users. Only 25% of the non-users have reported about being aware of the IUD, 23% have reported being aware of the Implant, 14% have reported about being aware of Tubal Ligation, and 10% were aware of the Vasectomy at the time of interview. The majority (70%) of the non-users reported being unaware of birth spacing methods before marriage, a large majority (92%) of the non-users favored the idea of inclusion of birth spacing related content in the school curriculum.

Non-users reported an average of 2.8 years as the ideal spacing period between two pregnancies. The majority (55%) of the current non-users reported ever using contraceptives in the past; most of those with use experience (66%) used oral contraceptive pills, 25% reported past use of condoms, and 9% had used injection. The chart below shows the past use of the different contraceptive methods as reported by the current non-users.

Figure 4: Mix of methods previously used by current non-users

Percent of Nonusers Methods Ever Used

■ Pills ■ Condoms ■ Injection



Mother in Law Profile:

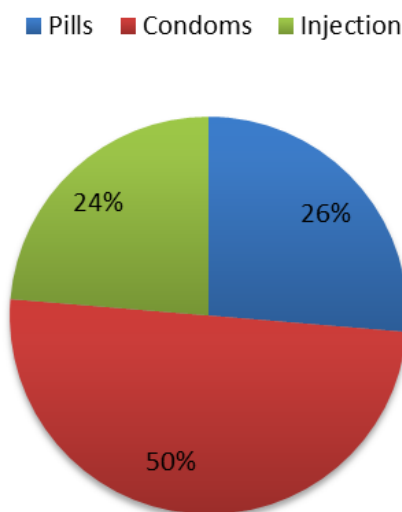
Data from a total of 34 mothers in law was collected. The average age of the respondents was 56 years with a standard deviation of the 9.6 years. The youngest respondent was 35 years old while the oldest was 80 years old. Mothers in law reported having an average of 7 children, 4 of the children were boys while 3 of the children were girls. According to mothers in law the ideal number of children was 6 with a preference for the boys.

Community Health Workers Profile:

Data from a total of 38 CHWs was collected. The average age of the CHWs was 42 years with a standard deviation of the 10 years. The youngest CHW was 18 years old while the oldest was 60 years old. The CHWs reported having an average of 5.7 children, 2.9 of the children were boys while 3 of the children were girls. Half (50%) of the CHWs reported condoms as their favorite method of birth spacing while 26% reported pills as their favorite method and injection was favored by 24% of the CHWs. The chart below shows CHWs' favorite methods.

Figure 5: Methods most favoured by CHWs

CHWs' Favorite Birth Spacing Method



When CHWs were asked about the methods most preferred by clients, about 62% of CHWs reported that their clients prefer pills. About 76% of the CHWs were able to provide some basic information about IUD, 35% about Implant, 23% about Tubal Ligation, and 3% about Vasectomy.

When CHWs were asked about ever attending training on family planning, 74% reported attending such training. Majority of CHWs reported that the most recent FP training was conducted more the 12 months ago. About 85% of CHWs reported attending a training regarding administration of injectable methods and the same percentage of the CHWs reported being able to administer injectable birth spacing method.

Religious Leaders' (Mullah) Profile:

Data from a total of the 31 religious leaders was collected. The average age of the religious leader was 38 years with a standard deviation of the 11 years. The youngest respondent was 26 years old while the oldest was 74 years old. Religious leaders reported having an average of 4.8 children, 2.7 of the children were boys while 2 of the children were girls.

About 90% of the religious leaders reported delivering sermons regarding breastfeeding during the Friday prayers. However, only 45% of the Mullahs reported that they have talked about family planning or birth spacing methods during the Friday prayers. Only 45% of the religious leaders reported attending conferences on Islam and Family Planning.

3.1 Objective 1: Factors at individual, couple and family level

The study findings reflect very close inter-linkage across individual, couple and family level factors in the child bearing and birth spacing considerations and experiences of couples. This may be attributed to the fact that the study was focused on use and non-use of modern contraceptives among married couples, and thus did not include and unmarried respondents of child-bearing age. Seven key factors are evident in the study findings as most influential in the use and non-use of modern contraceptives, namely:

1. The nature and strength of relationship between the man and woman who are together in marriage, especially as evident in their communication and dialogue about health and family development
2. The relationship between the couple and the parents of the husband, particularly as expressed in the living and life management arrangements between the couple and the parents
3. The family-level process of planning for child bearing and birth spacing
4. The personal perceptions and experiences of the couple and their parents of Islamic teaching on child bearing and parental responsibility, and on the specific guidance and instruction with respect to breastfeeding, birth spacing and use of modern contraceptives
5. The awareness scope and depth of knowledge that couples have about modern contraceptives
6. The actual childbearing and birth spacing experiences of couples and their parents, and the specific experience of previously using modern contraceptives.
7. The social networking among women and men

The results under this section are presented under each of these thematic areas of focus. The section also includes a synthesis of the main reasons that underpin unmet need for use of modern contraceptives.

3.1.1 Couple relationship and their communication on child bearing

The main factor that influences use or non-use of FP methods among the study respondents is the coming together of the woman and man as a married couple, and the relationship between the two people. Most of the user and non-user respondents indicate that consideration and decision-making about childbearing are based on discussion between the wife and husband within the context of the extended family unit. In a few instances, respondents indicated that they live separate from the extended family and thus have the opportunity of functioning as an independent family unit. The nature and strength of relationship between the wife and her husband, and the links they share with key extended family members are thus important determinants of decisions about child bearing and management of the spacing of births.

"I discuss with my wife about the number of children as she is my life partner. She always agrees with my decisions." – a man currently using contraceptives from Badghis province IDI233

"My family includes me, my husband and my children only; there is no one else. My husband tells me to have more children but I said to him that I can't manage more children so I don't want to give birth any more. But he wants more children and sometimes he talks about stopping of methods, but I don't agree with him." – a woman currently using contraceptives from Badakhshan province IDI315

"I and my wife are a family so I consult only with her. As my wife is an important and determinant part of my life so she has the right to have a part in every decision of our life." – a man not currently using contraceptives from Bamyan province IDI841

Most of the women and men respondents as actual or potential users of contraceptives indicate that they discuss with their spouses about child bearing, birth spacing and use of contraceptives. The discussions also reflect that this dialogue between wife and husband is the common context for the behavioral decisions and actions on to these issues

"I don't talk to anyone else about our children and how many children we should have, except my wife." – a man not currently using contraceptives from Kabul province IDI646

"When it comes to deciding about the number of children to have, I do not say anything because it is a personal matter and decision of the couple to make on their own." – a mother in law from Khost province FGD 931

"On the issue of number of children and their spacing, it is the responsibility of each couple to have enough discussion on the actions they need to take to allow their children grow properly. The couple should have an agreement between them on what method to use, so their child will be very strong and healthy." – a Mullah from Badakhshan province IDI361

The dominant results from such couple discussions on child bearing, birth spacing and contraceptive use appear to be a combination of agreement and consensus between the wife and husband, and submissive consent by the wife to the husband's views. This is largely based on the authority vested in the man, and the common perception (and frequent experience) that the husband has more knowledge, based on exposure to information sources outside the home environment.

"In our family, I have talked with my mother and wives that we don't get any other children, and they agree with me. But it is me to make the decision by myself, because I'm responsible for their education, nutrition and handling." – a man currently using contraceptives from Khost province IDI931

"I talked with my husband and we agreed to have fewer children. If we have more children our lives would become difficult; fewer children mean a good life. A family with fewer children is able to travel together comfortably." – a woman currently using contraceptives from Herat province IDI526

"I and my husband both made the decision to use birth spacing method, as my husband has the authority. I discussed with my husband regarding the birth space method, I only consulted my husband, and got the permission and then took the decision." – a woman currently using contraceptives from Bamyan province IDI816

"I consult with my husband as he is my life's partner. If he says that I should use the methods I will use them if he says that I shouldn't use them I will not use them." – a woman currently using contraceptives from Samangan province IDI413

"I discuss with my husband, he is literate, he understands me, and tells me to think about my health, and be happy." – a woman currently using contraceptives from Kabul province

Among a few of the respondents, there was a sense of sustained disagreement on some issues, which often results in continued uncertainty and no concrete decision and action. In some of such cases, the wife adopted actions contrary to the views and desires of the husband, especially with respect to adopting use of contraceptives, usually with effort to keep this hidden from the husband. The case example below illustrates some of these experiences. IDI616

Text Box 1: Differences in opinion and their consequences – A case example

IDI623 (30-year old man, married for 15 years, has 7 children (1 boy, 6 girls)

If it was upon my wish I would have one or two boys, but my mother-in-law says I should continue child birth. She says that since I do not have 20 children yet, I should bear more. My mother in law and father in law say as far as God is willing, I should continue bearing children because preventing child birth is a sin. My husband also says that if God has not stopped the bearing of children, we should not try to stop it.

I already have seven children, with only 1 boy. I had childbirth each year; I ended up breastfeeding each child for only 1 year. My husband's sister says that I should stop the child birth, and use the methods. In the beginning we used condoms but then my husband stopped using them and did not allow me to use another method. It is not up to me; whatever my husband says, that is what is good.

So what we can do, this is all from God. It is because the men are the ones to decide, we as women do not have the authority to decide. Our men will get angry with us, as they say don't do anything without our permission. Also from the Islamic point of view it is not good to use birth spacing methods, because the number of followers of our messenger Mohammad (PBUH) should be increased.

A few of the respondents indicate no or limited discussion at couple level on child bearing, birth spacing and contraceptive use. This is mainly in situations where the marriage was still in the first few months or years, usually with no or few children. It is also linked to other differences within the couple that lead to a strained relationship.

"We still want more children and have not discussed much on birth spacing methods. I know the methods are good I have a plan for one or two more children then we shall use them. In fact I have directed many people to go to the provincial hospital or to Keshem clinic and get information about family planning." – a man not currently using contraceptives from Badakhshan province IDI342

"I had hidden everything from my husband. I did not consult anyone. My mother in law and father in law did not give me permission to do birth spacing. My husband had told that I should give birth all my life until I die, and he is very happy to see many children. I also prayed Allah to bless me with many sons." – a woman currently using contraceptives from Kabul province IDI611

"I have not talked to anyone about child bearing and birth spacing. We have been married for only two years and I have no problem with the number of children to have, I want eight children – three girls and five boys. It is up to my wife if she wants to use birth spacing methods because she is responsible to take care of them." – a man not currently using contraceptives from Herat province IDI543

3.1.2 Relationship between the couple and parents of the husband

The study findings reflect that the couple relationship is most of the times imbedded within a multi-generational context in terms of perceptions and norms, and in the reality of co-location with the parents of the husband. The discussions on childbearing, birth spacing and use of contraceptives reflect the experiences and desires of the couple, those of their parents, and considerations of the welfare and development of the couple's children. This multi-generational influence is also evident in the prominent role that parents play in arrangements for the marriage of the couple, and often continues all through the marriage lifetime.

"Prior to marriage I had little information about birth spacing methods. But I observed that my mother had many children but not good life. After I got married, my parents advised me and encouraged me that more children are not good. I talked with father, mother, sister and brother in family about children because they are elder and had more experience. They said if I have fewer children I will be having better life." – a man currently using contraceptives from Bamyan province IDI836

"I tell my daughter in law that give birth to two sons and two daughters like me. It is easy look after them and afford their expenses. If you give birth to 10 children then you will not be able to maintain services for them." – a mother in law from Herat province FGD532

Virtually all the women respondents as actual or potential users of contraceptives, and many among the men, indicate that they discuss with the husband's mother on issues of child bearing, birth spacing and use of contraceptives. Inclusion of the husband's father is much less frequent, mainly in form of follow-on information and consultation by the husband's mother. This appears to be in close keeping to the norm of women having overall responsibility for issues and decisions considered to be internal to the home, while the men focus on their responsibility for issues and decisions outside the home setting.

"If my daughter in law has bleeding I share it with my husband as he is the elder of our family. I also share it with the wife to my husband's brother, because she is wiser than us and knows better." – a mother in law from Herat province FGD532

"Most of times, I discuss it with my wife and sometimes I discuss it with my mother as well. my wife says she should have a boy and my mother also insist to have a grandson." – a man currently using contraceptives from Kabul province IDI634

"I talk to my father and he says more children could not be raised well, and fewer children can be raised well." – a man not currently using contraceptives from Kandahar province IDI743

In the cross-generational dialogue on child bearing and birth spacing; the experiences of the parents of both the wife and husband are a common reference point for decisions concerning the couple. In some cases, the perceived benefits gained from having many children are a basis for encouraging large numbers of children for the couple. In other cases, the problems experienced as a result of getting many children are used by the parents to encourage fewer children for the couple. In a few situations, parents that had few children encourage larger numbers for the couple as an indirect way to realize their own unmet childbearing desires.

"In my opinion the couple should have 6 children 4 boys and 2 girls. The boys should be more because I have only one son." – a mother in law from Jawazjan province IDI051

"We get counseling from my mother and father. My mother says that they did not use any such things when she was young. We had submitted to the will of God. Now, time has changed, you have clinics, you have medicines, so it is up to you if you are using methods or not." – a man currently using contraceptives from Kabul province IDI636

"My daughter in law says she does not want more children, but I don't like to have only a few grandchildren. I had only two children so I don't want a few sons for my daughter in law. There is no difference for me whether they are males or females. But the increased number is important for me; I want an extended family with many children. I have told my daughter in law that whenever she bears more children, I will help her with house work." – a mother in law from Kabul province IDI655

"I tell my daughter in law that give birth to two sons and two daughters like me. It is easy to manage their training and education and afford other expenses. If you give birth to 10 children then you will not be able to maintain services for them." – a mother in law from Herat province FGD532

The dialogue between reproductive-age couples and their parents about contraceptives is largely dominated by consideration of use with a focus on three main perspectives: a) the benefits of using contraceptives with respect to welfare of children and mothers within the limits of the economic capacity of the family; b) their understanding and interpretation of Islamic teaching about contraceptive use and other issues relevant to child bearing such as breastfeeding; and c) the importance and feasibility of having more children, especially in view of availability of other members of the extended family to support the wife in childcare. It is notable that there is limited focus on the problems or negative effects of contraceptive use in the family-level dialogue between couples and their parents, yet these concerns dominate the discussions of women and men of reproductive age and their peers.

"My daughter in law likes to have children and now she has been pregnant for 8 months. She says that I like children because my husband likes them. But I was telling her for 2 years you should not give birth to another one till the first grow up. I told her to use tablet to have birth spacing, because it is difficult to manage the children." – a mother in law from Herat province IDI553

"I talked with my sister in law and we agreed that if Allah gives us two more boys they will be enough. But my father in law says if Allah does not give you boys I will get another wife for my son. My husband has also said that if you stop giving birth I will get married again. My husband does not give me permission to use birth spacing methods. He says Allah provides everything for the children given; and I will be responsible to meet all the needs they have." – a woman not currently using contraceptives from Kunar province IDI124

"For a poor man 2-3 children are good and if someone can afford and has no economic problems and has ability to educate them well so, many children are good." – a mother in law from Kabul province FGD632

"If my daughter in law talks with me I will tell to her to bear more children as this is from Allah. I do not give permission to my daughter in law to used birth spacing methods. She should have 8 children." – a mother in law from Badakhshan province FGD332

It is notable that virtually all the discussions about contraceptives between reproductive age women and men and their parents as reflected in this study take place after marriage of the children and when they have commenced child bearing. There is very limited discussion of such issues with children that are not yet married; not even in the process of preparation for marriage such as the period of pre-marital engagement. Similarly, there are very few instances of such discussions in the early days of marriage, for example to consider when a couple should initiate childbearing.

Many of the reproductive age women and men respondents reflected a common thread that the age at which they married and the process that led to the marriage were largely determined by the parents and other older family members. A few among them indicated having had some discussion with their parents about child bearing and birth spacing before the marriage. Some of them also indicated having such discussions with their own children, especially those children considered to be old enough; some of them already married.

Consultation and dialogue with other family members: In addition to dialogue with parents of the husband, another form of family-level discussion on child-bearing, birth spacing and contraceptive use discussed in this study was between the reproductive age women and men respondents and their peers in terms of age and life experiences. These include brothers and sisters of the husband, wives of the husband's brothers (usually living in the same extended family setting), and other categories of relatives. Their relevant discussions mainly focus on child-bearing experiences and expectations, experiences using different birth spacing methods, and the challenges related to raising children and enabling them to be better equipped and empowered to live productive lives. It is notable that such discussions were more evident in the discussed experiences of the women than the men respondents.

"I talk with my wife, my brother and my children. My mother and father and relatives have encouraged us to use birth spacing methods. The CHWs have been talking about the methods in our community, but we have not used them yet because we want to have more children [now 5 children, 3 male, 2 female]. We plan to use them in future to have space of 2-3 years between births." – a man not currently using contraceptives from Badghis province IDI243

"I consult with my husband, mother in law and my elder children. They don't like that I should get any more children." – a woman currently using contraceptives from Badakhshan province IDI316

"I talk with my brother. He tells me that it is good to have four children so you can raise and educate them very well." – a man not currently using contraceptives from Khost province IDI944

"My uncle's wife came to our home and when she saw our lifestyle and poverty she said: why don't you take pills to prevent pregnancy? So I replied that my husband does not allow me to use the pills." – a woman not currently using contraceptives from Kabul province IDI624

Consensus, difference of opinion and decision making at family level: It is evident from the discussions of respondents of all categories that there is great effort at extended family level to share and inform the decisions of couples about child bearing, birth spacing and contraceptive use. While there is indication of interest to achieve consensus between the wife and husband and the other family members consulted, the common underlying recognition is that the couple has the final mandate to make the decisions. In many situations, the dominant perspective is that such decisions are based in the ultimate authority of the husband as the family head. However, in some cases, the dialogue and decision making on these issues is more in the realm of women in the family (the wife, the husband's sisters, the mother of the husband, etc.) as part of their mandate and responsibility to manage the affairs internal to the family. This represents an important potential basis for expanded male involvement as well as enhanced women-led decision making on these important issues.

"Yes we discuss about this issue. My daughter in-law is a very good woman and I tell her let the children get grow and understand what is good and bad then birth another child, and thus they and their children will not be torment. My daughter in-law is not bad, but her mother is a bad woman. She always tells my daughter in law that I am jealous of her and I don't want her to have more children. Actually I do not interfere how many children they want but I advise her to let her children grow first before giving bith. My son's income is also not enough and sometimes we face economic problems." – a mother in law from Jawazjan province IDI053

"It is a couple related issue that how many children they should have, I do not interfere." – mother in law from Herat province FGD531

"We seek counselling from father, mother and the elders of the family, especially with my wife. She listens to me and accepts whatever I tell her. Whatever father, mother or I tell her, she agrees." – a man currently using contraceptives from Kabul province IDI636

"I decided myself to use the methods. My husband did not want me to use the injection; but no one can prevent me. I consult with my mother and mother-in-law; and I got permission to use the method." – a woman currently using contraceptives from Jawazjan province IDI016

"We use condoms. We did not use any other method. We use this method secretly from our father in law and mother law, as they don't allow us. My brother's wife, my sister and some others told me about the method and my husband and I were not aware of it. My mother in law does not know about it.If she knows she will prevent us from doing so. My mother in law's aunt also says that a lot of children are good." – a woman currently using contraceptives from Kabul province IDI613

A notable area of important influence at family level is the child bearing and economic progress experiences of siblings in the family. On one hand, if some siblings have few or no children, this may be the basis of personal decision or pressure from other family members to have more children. In other cases, siblings that have many children, often in association with other parameters of perceived family success (e.g., growing business, family assets, etc.) may stimulate feelings of jealous and competition in areas including child bearing.

"My husband's brother has many sons and daughters. He has a shop, a car, a daughter in law, grandchildren, and many more things. I should also have these things. We have so much jealousy between our families." – a woman not currently using contraceptives from Kabul province IDI624.

3.1.3 Family level planning for child bearing and birth spacing

The study findings reflect that the child bearing and birth spacing considerations for a couple may start long before the couple comes together in marriage, and continue into all the years of child bearing potential in the marriage. On one hand, the parents may have specific fertility expectations of the children, which they express in different ways as the child grows up. On the other hand, the child also develops their own reproductive expectations and plans, especially if they have the opportunity to grow through adolescence and early adulthood before they marry. The respective ages at which the woman and man get married, and the process and key actors in the marriage, represent an important opportunity for open and in-depth dialogue and planning on this issue. In the experiences discussed by most respondents, the dialogue and planning for child bearing and birth spacing by the couple continues to deeply involve their parents long into the marriage. The case example below illustrates some of the experiences.

Text Box 2: A family planning for fertility management

IDI313 (35-year old woman, married for 13 years, has 4 children - 2 male, 2 female)

I studied up to ninth class. In the past there were no FP methods available. My mother had 10 children and married off her daughters when they were very young. If she had few number of children or had more sons she would have allowed us to continue our studying and when we were big enough then she would get us married. When I married I became pregnant. My father in law and mother in law didn't allow me to continue my studying. I didn't know about FP. I was 16 years old.

When I had successive childbirths I couldn't manage my children so I started to use injection method. At first I decided to use the FP methods and then my husband agreed and allowed me to use the injection method because dealing with the difficulties of taking care of the children is directly up to the parents. My mother in law and husband were always opposed to using FP methods but now my husband is no longer a barrier. My mother in law still does not agree to my use of the FP methods. She says: "give birth to children I will help you in caring for them. You have no job outside the home; why are you not able to have another child and care for them? The women of nowadays are useless."

Because the method creates birth spacing it will allow me to raise my children better. I will manage my home's work better, I can educate my children better, and my children will be healthy. It does not matter that I married a villager but I am a person from the city. I want my children to look different from other's children.

The fertility planning at family level as expressed by study respondents largely focuses on child bearing as the foundational purpose of marriage and family life (the default mode). The fertility and/or childbearing of a couple are seen as primarily dependent on God's will and providence. The human role and responsibility is largely seen as belonging to the man and woman together as a married couple, informed and supported by the knowledge and experiences of other people in their immediate social circle. The family-level planning in this respect is also recognized by study respondents at policy and program management levels as a critical starting point and building block for population and development planning.

"We do not have any family plan. That is Allah's wish whether he blesses us with more children or not. But if Allah blesses us with a child, then the sex does not matter; son or daughters, both are the same for us." – a man not currently using contraceptives from Bamyan province IDI846

"I want to have 10 children; 6 girls and 4 boys; because a child is the fruit of parents. Parents are like a tree and their children are fruits of the tree." – a man not currently using contraceptives from Samangan province IDI 443

"It is Allah that gives children; it is not the choice of servants." – a woman not currently using contraceptives from Herat province IDI523

"One of my daughters in law has 6 children and another has 2 and I like them all. My younger daughter in law has fewer children and may God give her more children because I like to have more grandchildren." – a mother in law from Herat province IDI551

"Because we don't like it and we don't need to use. We have just been married for one year, and have only one child. We didn't think about it yet, but in the future maybe we will use it." – a man not currently using methods from Kandahar province IDI741

a) The family level planning process is informal, iterative and cross-generational

The family-level planning for child bearing and birth spacing as reflected in study findings is often informal and integrated in other life events such as working together, moving together on a journey and meal times. Two broad strands are evident among the issues of focus in such planning. On one hand, there is responsive planning in reaction to problems as they occur or get noticed. This includes problems of mothers, such as maternal weakness and poor health; and its link to child bearing. It also addresses issues about children such as illness and other features of poor wellbeing (malnutrition, etc.); and problems meeting the specific needs of children (education, etc.).

On the other hand, there is pro-active planning to address the evolving anticipated actions in child care and upbringing as the children grow; and on the future of children and how to ensure it is bright. This includes considerations for birth spacing to ensure the right number and focused care and nurture, preserving the mother's strength to ensure good care, work and income for the father, etc.).

"Mostly the first and second child is born with having minimum interval. After that experience, the parents start to consider long time period birth spacing, like 4 or five years, and they use birth spacing methods." – a woman currently using contraceptives from Herat province FGD511

"Some of my relatives say that they want 4 children and some of them say 5 children. But the time is now changed. In the past people gave birth to children each year and now people are educated and wise and they say that 3 or 4 children are enough because they can be raised and educated well." – a man not currently using contraceptives from Khost province IDI947

"I decided to have 10 sons and 6 daughters because our homeland is poor, and our tribe insists that I need to have many supporters so that we are not weak but strong against our enemies. I have not consulted anyone, this is my decision." – a man not currently using contraceptives from Kunar province IDI146

"In my opinion (each individual) has his/her own opinion, and they have a program for their life. If a person has 4 or 5 children, not more than 8, that will be great. Everyone should have at least 6 children. As there are problems in the country, so if we have more boys than girls, that is good. Boys give strength to family. When people have many sons they get happy because sons stay with parents." – a man currently using contraceptives from Kabul province IDI635

In some situations, a problem or a concern may be expressed and discussed between two people, for example the couple, or the wife and her mother in law. Additional family members may be drawn into the dialogue; usually as a serial process, and on a few occasions as a structured discussion with multiple participants.

The experiences discussed by study respondents reflect that such informal engagement with an issue may go on for some days or even months; often moving back and forth between different people. In many cases, there is limited progression to generate agreement and action decisions, which is partly attributable to inadequate information or guidance. In some instances, there is consensus on seeking external guidance, for example from health service providers, Mullahs, etc.

The cross-generational nature of planning in the family continues to involve the couple and their parents, and often extends to the couple's children. A number of couple respondents expressed child bearing considerations that are largely based on the childbearing experiences and expectations of their parents. In discussions about child care needs and expectations, the mother in law/grandmother often plays a key role in providing guidance and physical support to the wife. As the children grow up, especially if they go to school and learn new things, they have room to contribute to the family planning process. In some cases, the couple plans in consideration of their support expectations from the children, especially during old age.

"My mother in law creates barriers for me on using of FP methods. She does this because she has three children so she wants me to have more children." – a woman currently using contraceptives from Badakshan province IDI316

"Having children has benefits; if I and my husband get old the children will help us. The girls will get married and will go to their husband's house but our sons will stay with us and will help us." – a woman not using contraceptives from Herat province IDI522

"I have talked to my wife and my mother about the number of children and my wife agrees with me that 4 children are enough. Sometimes my father stops me from using because he wants more children but I tell him having more children is not good." – a man not currently using contraceptives from Khost province IDI945.

"In family I talk with my husband about how to provide the children with good food, clothes and education and how to raise and nurture them well. Then they will be able to help us when we become older." – a woman currently using contraceptives from Bamyan province IDI813

b) The planning mainly focuses on problem-solving; and begins when problems occur

The planning for child bearing and birth spacing as discussed by respondents is largely triggered by experienced problems, mainly in relation to the number of children they already have. One of the key considerations is the economic situation of the family, and their ability to afford the needs of raising and educating the children. Another factor highlighted by many respondents is the health and wellbeing of the mother, taking into consideration the toll of pregnancy and childbirth, and the burden of caring for the children. In a few cases, the concern that sparked off planning for childbearing is related to the fear of transmission of disease from parents to children; or from one partner to the other (condoms use for dual protection). The views expressed by many respondents reflect attainment (or even exceeding) the desired number of children, and a desire to completely stop child bearing.

"I have Hepatitis B so I am going through condom use. I went to the clinic to check myself, and after checking they told me "you have Hepatitis B." I asked them what should I do; and they suggested to me using condoms to protect my family from Hepatitis B." – a male current user of contraceptive from Kabul province IDI633

"I like to have more children, but I have a problem and all my children have the same problem. That is the reason that I and my wife are using family planning methods." – a man currently using contraceptives from Herat province IDI536

"Those families who are rich and have good economy, they can raise and educate their children well. But my family's economy is weak that's why I planned to have 4 children." – a man not currently using contraceptives from Khost IDI945

"Before marriage I did not know about birth spacing methods, since we were not thinking about these issues. When I gave birth to more children, I became exhausted and went to get the contraceptives." – a woman currently using contraceptives from Bamyan province IDI811

In a few cases, respondents indicated pro-active planning for childbearing, usually early in marriage to delay the start to child bearing.

"When we got married and I didn't want to have children very soon so I went to clinic and they persuaded me. We used injection until the time we wanted to have a child. That is why we stopped using it." – a man not currently using contraceptives from Khost province IDI944

"My wife is a student and wants to complete her graduation. We consulted each other and we reached to consensus; we both decided to have birth spacing." – a man currently using contraceptives from Badghis province IDI236

As part of the 'problem solving approach' to fertility; the following issues emerged as key areas of focus in fertility and birth spacing planning and decision making:

1. Desire for balance in the sex of children there is more interest expressed in having boys, but also clear and strongly held desires to have girls (especially in situations where more or all of the current children are boys)
2. The desire for more children – especially in situations of one or a few children after some years of marriage, and with experiences of child deaths and pregnancy losses
3. The need to pause after getting a number of children; with the open possibility to have more children in future
4. The desire to stop having children; usually based on reaching or even having exceeded what is considered the desired or the ideal number of children

"I talked with my friends and with my husband and they say you can get more children because you are strong and also you love children. My husband also says that if Allah gives us two more boys that will be enough." – a woman not currently using contraceptives from Kunar IDI126

"I know someone that has one child since 12 years of their wedding. Now she is pregnant all of them are happy of their second child. People thought that his wife became barren, he must take another wife. All of their relatives told the man to get another wife." – a man currently using contraceptives from Herat province IDI521

"I have talked with my husband, as we are houseless, so the neighbors will get in trouble with us because of our many children. But my husband told me that how many children I bring is not a problem although I told him that, there is joblessness and it is difficult to feed and clothe them therefore we should not bring more children." – a woman currently using contraceptives from Kabul province FGD612

"I don't want this number of children; but now that Allah has given them to us, I pray for their lives. By God's mercy my daughter has now grown up; I don't want another child. Anything that I have we eat it by sharing; the more children make the life difficult. ...I am not complaining that I have too many children; all our children go to school. Even the fourth child is now 3 years; and will start school at 4 years." – a woman not currently using contraceptives from Herat province

"The parents evaluate the life condition and then decide about getting children. If their life is good they want to have more children if their life is not good economically to try to have not more than three children." – a woman currently using contraceptives from Bamyan province FGD811

c) Key considerations in the planning process: gender-based role allocation for wives and husbands; and the child sex, number and spacing

The perception that dominates family level planning about fertility and child bearing is appreciation of the high value and great importance of children to the couple, the extended family and the society at large. This is also strongly based on the Islamic teaching about the will and purpose of Allah in giving children to families, and providing for their sustenance. Both perspectives underscore a strong desire (and often a felt duty or compulsion) by couples to have many children.

Text Box 3: Experiences in family level planning – A case example IDI635 (40-year old man, married for 16 years, has 6 children (3 boys, 3 girls))

We already have six children and we don't want any more. We can't afford to have more children, as we live in a remote area and the education facilities are not good there. There is no opportunity for better education and we can't afford to send our children to urban areas for education.

My wife and I have been discussing this issue a lot. She has many positive suggestions regarding this issue, about she is also getting weaker. We have used different kinds of methods. First I used condoms together with pills but this caused problems in her tubes. We changed to injection and it caused problems in menstruation in the first months, but later the problem was solved and we are now happy with that method.

There are very few people among our relatives and neighbors who use birth spacing methods. Most of them ask me about the methods, and I encourage them to go to the nearest health facility to get the services. The methods are available in different places such as private pharmacies, private clinics, and the hospitals. The government has put efforts to make them available everywhere, in BHC and CHC and other hospitals.

In contrast to this strong pro-natalist attitude, there is also strong recognition and deep consideration of the cost of bearing and raising children; and there is clear allocation of this responsibility to wives and husbands. On one hand, the child bearing and care responsibility is seen as fully belonging to the wife/mother, assisted by other females that may be present in the family. There is recognition that this places a high demand on her body, especially if the spacing between births does not allow for the necessary rest and recovery, and as the number of children born increase. The physical and psychological/mental strain exerted on the mother by child care and nurture tasks are also well recognized.

"As I am uneducated, I do not have enough information about family planning methods. But I want to have a small family; and I want to provide all facilities to my wife and family." – a man not currently using contraceptives from Bamyan province IDI844

"The issue is not whether you have more children or fewer children, the key question is: do the children go to school every day? Now the situation is different from the past. In past, the parents had not had difficulties to take care of their children. But now the children need to nurture well a lot of expenditures. The parents are responsible to send their children to school." – a woman not currently using contraceptives from Herat province IDI525

"I don't want more children, because my last child is 3 months old and the elder one is 3 years old and he cannot walk and talk, and that is why I am facing problems." – a woman not currently using contraceptives from Bamyan province IDI823

"We talked to people related to health sector and sometimes we talked with our Mullah as well. I consulted with my wife and she became happy when I told her that this number children are enough." – a man not currently using contraceptives from Kunar province IDI144

"There is no difference for me that how many daughters or how many sons my child should have. What is important for me is the number; I want an extended family with increased number of children. I have told her to have two daughters and two sons, as I had only one daughter. She always told me: "my mother! I am alone, if I had a sister, I would not feel so lonely." I have told to my bride for the time being I have a job, and she should use the methods, whenever my job finishes, I will help her in raising my grandchildren." – a mother in law from Kabul province IDI655

On the other hand, the husband bears the responsibility to provide for all the child care and upbringing requirements, and for the personal well-being of the wife. His ability to meet this responsibility is an important influence on the perceptions and decisions about the number of children to have. However, this is also influenced a lot by the perception that Allah always provides the means to sustain all children as given to each family.

"We are not able to take care of our children because my husband is a laborer, wheeling goods in the city. However we try to work hard, but still we are not able to take care of our education as it is very expensive. That is why we need to take responsibility and use family planning." – a woman not currently using contraceptives from Herat province IDI525

"The five children we have are enough for me; but even 10 children are fine. We are happy to have more children. I do not have information about birth spacing methods but I really do not care about such things. Whatever number of children Allah gives us is fine." – a man not currently using contraceptives from Kandahar province IDI745

"If a couple is wealthy and have no financial problem, they may have 4 children, 2 sons and 2 daughters." – a woman not currently using contraceptives from Herat province IDI522

"I am a poor person, so eight children will be enough and the number of my children considering their gender should be equal." – a man currently using contraceptives from Kunar province IDI136

The other key consideration in planning child bearing and birth spacing is the perception of adequate children; which is largely based on three dimensions: the sex of children (especially the presence of 'enough' boys); the total number of children; and the perceived health of the children or their chances of survival and future reproduction. In view of the fact that this planning process at family level is reactive and iterative in consideration of these factors, the stated perceptions of ideal number of children are not reflected in the actual child bearing experiences of many respondents.

"I plan to have 2 more children, to get a total of 8 children. The boys should be more and the girls should be less; but this is up to God to decide. This is my idea; I have not discussed it with anyone." – a man not currently using contraceptives from Kandahar province IDI744

"In the past people said that more children are good so they could work. But now fewer children are good in order to maintain good life. Wise and educated children are good. It is good because it is possible to maintain their services." – a man currently using contraceptives from Bamyan province IDI832

"I want to have five more children and all of them should be boys. I have land and livestock and I want to have an owner for the land and livestock after me." – a man currently using contraceptives from Kabul province IDI633

Semi-quantified analysis of the data from married women and men reflect that those currently using contraceptives report having an average of 4.8 children, 2.5 of the children were boys while 2.3 of the children were girls. On average they desire one more children than their average number of children; that is, a desire for having an average of 5.9 children was reported by the respondents currently using contraceptives. On the other hand, the respondents not currently using contraceptives report about having an average of 4.4 children, 2.1 of the children were boys while 2.3 of the children were girls. On average the non-users desire two more children than their average number of children that is, a desire for having an average of 6.2 children was reported by the non-users.

The considerations of birth spacing in family level fertility dialogue and planning as reflected in respondents' discussions focus on three key aspects:

- A. The need to provide adequate time for full breastfeeding of the child (stated by most respondents as two to three years);
- B. The need for adequate time for the child to grow up and have some level of independence from the close care and support of the mother; and
- C. The need for the mother to recover from the effects of the previous pregnancy, delivery and to a less explicit extent from the effect of child care and nurture.

"The space between births must be three years at least. That will be good that mother be able to take care of the children and of her husband. The women have a lot of work in the home; they are always busy. The mother can take care of the children in a good way with good spacing." – a man not currently using contraceptives from Herat provinces IDI544

"Three years time interval between births is good. If you have fewer children, the woman will be able to give birth with no problems. The women become anemic and weak if they deliver a child every year. If the women deliver children each year, they will not be able to take care of their children. The less children the better life you have. The parents can take care of their children (their dressing, medicine and doctor) and it is also good for the parents themselves." – a woman not currently using contraceptives from Herat province IDI526

"My three children were born without adequate space between them; they did not have enough breastfeeding and they distressed me so much. I am encouraged by the experience of the wives for my brother in law; they have well-spaced and healthy children, and are fresh and happy. I have talked with my husband using family planning methods and I hope that by the mercy of Allah, he will agree." – a woman not currently using contraceptives from Kunar province IDI123

"We have seven children but if Allah blesses us with more children, then we will want to have some space between them." – a man currently using contraceptives from Kandahar IDI731

It is notable that the perceptions of ideal birth spacing for most respondents closely match the period of complete breastfeeding. There is limited consideration of the necessary transition period from breastfeeding of the child to the time over the next pregnancy until the point of delivery. In the few instances where this is factored in, a longer period of ideal birth spacing (usually between three and five years) is indicated as appropriate. In some instances, respondents noted an important connection between the need to ensure that the child benefits from the full period of breastfeeding, and the consideration of using contraceptives to enable mothers achieve this ideal.

"One or two years birth space should be there. But I gave birth to children each year. It means that before the first child was one year old, the other one was born. I provided breastfeeding to each child for only one year." – a woman not currently using contraceptives from Herat province IDI623

"In my opinion, it is good if there is two years space between births. Because we can raise healthy and good children in the community, and have fruitful results in future." – a man currently using contraceptives from Bamyan province IDI836

"Three to four years space between births is good. In that time a mother can recover the blood and other loses she suffered because of child birth." – a man currently using contraceptives from Bamyan province IDI832

"Contraceptives are good. If someone uses them, it will be good for her because she can recover better and her life gets better. Those who don't make space between their childbirths are harming their own bodies. But if someone gets a child too soon, what can she do? A baby is so sweet; you cannot do anything about that. A child is always good; never bad." – a woman not currently using contraceptives from Samangan province IDI425

3.1.4 Personal perceptions of Islamic teaching on childbearing and birth spacing

Islamic teaching and its personal interpretation by respondents is an important influence on planning of life and how it is lived in the different spheres, including child bearing and birth spacing. The perceptions of respondents in this respect are shaped by their exposure to and participation in regular Islamic teaching (e.g., in Madrassas, regular Juma prayers, media-based Islamic teaching, etc.), and through inter-person dialogue on faith and its life implications.

The discussions of most respondents reflect the commonly held view that child bearing, nurture and instruction in Islam are a religious duty of adults in marriage. Central to this view is the recognition that it is Allah that gives children to families, and determines their number and sex. It is also Allah that provides the means to sustain the children; through the direct abilities and opportunities granted to the parents, and through additional means as may be necessary such as the giving and support of other people.

The dominant perception among respondents is that parents have the responsibility to raise the children well, through the necessary physical care (e.g., provision of food, shelter, health care), and through appropriate nurture and protection (e.g., from illness and early death). The parents also have the responsibility to instruct the children in appropriate manners and morality, largely based on Islamic teaching and with a view to grow into adults that are useful to society.

"We talk about Islamic teaching; that God's peace to our country, so we could live under Islamic teachings. With mercy of Allah we have children. I have one daughter-in-law, who has six daughters and a son. I wish God gives her two to three sons; the daughters are now enough." – a mother in law from Kabul province IDI653

"Allah blesses some people with children while some not. It is the will of Allah and also it is not a problem. But if someone doesn't have children or have less children, then people say that they have problem or they cannot give birth to children. The important thing is that we should provide them with every thing." – a man currently using contraceptives from Kunar province IDI134

Another area of Islamic teaching highlighted by household level respondents as important in childbearing and birth spacing is with respect to the duration of breastfeeding. The common perception is that Islam instructs that all children should be breast-fed for at least two years, ideally for up to three years. Some respondents indicated a specific teaching that girls should be breastfed for a longer period, justified from two main considerations: a) their unique needs as the 'weaker sex'; and b) in preparation for their future role of breastfeeding their own children.

"Islamic teaching about breastfeeding is two years and two months for a son, and two year and four months for daughters. This is because the daughters are weak and they have the responsibility of breastfeeding their children in the future." – a woman not currently using contraceptives from Herat province IDI521

"The Mullah said that birth space should be about 27 to 30 months, to allow for enough breastfeeding to the first child. We are Muslims and we are following all rules and regulation of Islam. We don't deviate from Islam; we don't want to do sin. Everything said in Islam we accept; I will do JIHAD for Islam." – a man not currently using contraceptives from Khost province IDI943

A number of respondents indicated that they had been able to meet this ideal with respect to their children, and acknowledged the evident benefits of the resulting long birth for the child and the mother. Some indicated that this was enabled by use of contraceptives to delay the next pregnancy. However, many respondents acknowledged that ideal was difficult to achieve in the child bearing experiences of many families.

There are mixed views about breastfeeding practice and how this influences the next pregnancy and birth spacing. Some respondents appreciate the link between breastfeeding and delayed return to monthly menstruation. Many respondents recognize the resumption of monthly menstruation as an indication of potential for the next pregnancy, and the need to use contraceptives if this is not desired. However, there is also some inaccurate attribution of a pregnancy prevention effect to breastfeeding for the complete period of two to three years.

"The benefit of using contraceptives is birth spacing and prevention from pregnancy during breast feeding. These methods should be used to create birth space; otherwise frequent childbirth will result in having weak children." – a man not currently using contraceptives from Jawazjan province IDI043

"I have breastfed more my children as a way to prevent pregnancy. I breastfed my son to prevent pregnancy; and he is now three years old!" – a woman not currently using contraceptives from Herat province IDI525

"If the use of birth spacing methods is based on an acceptable need, Islam has no problem with it. Islam permits use of birth spacing methods to ensure that each child is breastfed by the mother for two years because this is the right of every child." – a man currently using contraceptives from Kunar province IDI136

"Before I did not know about birth spacing but now I know. The birth space between two births should be two or three years. It is better because breastfeeding a child will go on until two and a-half or three years, then the other birth should take place." – a man not currently using contraceptives from Jawazjan province IDI041

Many of the respondents perceive the use of contraceptives as strictly prohibited by Islam, categorized as a sin and interpreted as human attempt to prevent the will of Allah or to murder the children that Allah has given. However, some among them also indicate Islamic teaching and interpretation that explains and justifies the use of some contraceptives and in specific conditions of the family. The situations indicated as acceptable or justifiable for contraceptive use include the following:

- A. The limited economic ability of the husband to support more children as a basis for the family to stop child bearing
- B. The need to ensure the health and well-being of the child, and his or her future development – including the effort to enable longer spacing between births to allow for full breastfeeding, and to limit the final number of children so that all of them can be supported to develop to full capacity (e.g., through education)
- C. When the health and wellbeing of the mother is threatened by child bearing, especially if this is seen as affecting her ability to care for and raise the children well

"My husband prevented me and does not allow me to use birth spacing methods. He says if I give you permission to use these methods, I will feel guilty and become sinner because it is a sin. ... I am going to use the method but I don't think my husband would allow me because he is a religious scholar. He is so strict on such issues and he always says that children are the blessings from Allah and we should be thankful of this blessing." – a woman not currently using contraceptives from Kabul province IDI624

"It is a mercy of Allah to humans and it is also Mohammad (PBUH) saying that increase the followers of him. The Mullah says that using birth spacing methods is a sin. We also feel that if it is sin that we are using these methods, then we ask Allah to forgive us." – a man currently using contraceptives from Kunar province IDI132

"There is a hadith in this regard saying using birth spacing methods is good. Using of methods is legitimate, and does not have any obstacles according to our religion, rather it is emphasized." – a man currently using contraceptives from Bamyan province IDI832

"We consider the use of family planning methods as a sin; that is why we do not use them, and we will not use them in future. Our religion says that it is a blessing of Allah to give children to a family. We have no reason to stop Allah's blessings." – a man not currently using contraceptives from Bamyan province IDI846

3.1.5 Awareness and knowledge about modern contraceptives

Awareness and knowledge of birth spacing methods was discussed in this study from five main perspectives:

- A. Awareness about the methods among married women and men during the time before they got married;
- B. Current awareness about the methods among married women and men, and among mothers in law;
- C. The scope and depth of knowledge that married women and men have about the methods;
- D. The information sources that respondents have used to learn about the methods and
- E. The ideal information sources that should be used to reach adults and young people with information about birth spacing methods.

The study results with respect to each of these elements are presented in this section. The textbox below presents an example of the awareness and knowledge present, and reflects how this shapes attitudes and practices with regard to use of the methods.

Textbox 4: Birth spacing awareness and attitude – A case example
IDI543 25-year old man, married for 2 years, has 2 children (1 male, 1 female)

I have no problem with how many they should be, I want 8 more children, 3 girls and 5 boys. Having more children is good because with having more children, it impacts a lot in life. Ideally, a couple should have 7 Children 4 boys and 3 girls. The birth space must be 2 years, so the child could have enough breastfeeding. If the women breastfeed the child for two years, naturally they don't bear another child for two years.

I have talked with no one in the family about the number of children to have. I have got some information about birth spacing methods from the television and internet. I had no information about these issues before getting married. Now I know about Tablets, IUD, condoms and implant. Tablets make the heart weak and are harmful for the stomach. The condom is harmful for men, it can cause blocking of urine and cause kidneys problems. I have no information about IUD; and also about implant and tubal ligation.

To inform people about contraception methods, it is better to have people gathered in mosques; and to inform the married women through women health staffs. If possible, this matter should also be shared in school with students. My wife can also be informed and she can decide if she wants to use the methods, because she is responsible for raising and take care of them. For me I am busy with my life.

Some people say that using the methods is a sin according to Islam. For me I think everyone is responsible for his/her own deeds. If a woman is young and able to bear a child, it is a sin for her to use. If a woman is older and she uses, there is no problem. This is because some people get problems as they age and they need to do contraception. Women that are young should not use.

Awareness about birth spacing methods before marriage

Most respondents indicate that they had no awareness about birth spacing methods before marriage, as part of general limited awareness and inexperience of young people. This was partly attributed to the culture and tradition of deliberate restriction of exposure to information for children and young people, as an integral element of parenting and child upbringing. Other reasons mentioned include: inadequate health facilities and thus limited access to such information, marriage at an early age (when I was still a young girl), general lack of awareness due to limited literacy, etc.

"I did not know about such things because I was restricted at home all days and nights. Now I know about method since I got married. Nowadays all girls know about this before getting married." – a woman not currently using contraceptives from Herat province IDI521

"I did not know about birth spacing methods before marriage, as I was little girl at that time." – a woman currently using contraceptives from Bamyan province IDI816

"I was not aware about the birth spacing methods until my third or fourth baby. Later, I started using tablets and then injection. In the past people were not aware of the methods; it was only later that people learnt as clinics and health workers became available." – a woman currently using contraceptives from Herat province IDI514

"I did not know about family planning before getting married. I had no information about many things; in fact everything." – a woman not currently using contraceptives from Kabul province IDI622

"No, before marriage I did not know about it. We were like blind people and we did not know many things." – a woman not currently using contraceptives from Kabul province IDI623

"In the beginning when I got married I didn't have information because clinic and health workers were not available in that time. I married 25 years ago and none of these were available that time." – a man not currently using contraceptives from Bamyan province IDI842

However, a few among the respondents indicate some awareness about birth spacing methods before marriage. This awareness is mainly gained from family-level dialogue; with most such respondents indicating that they were told by mothers or other older women in the family. The other opportunities used to learn about methods are: interaction with people that are using or have used the methods; information from CHW or training as CHW and other categories of health-related volunteers; hearing from health professionals during visits to health facilities; and through personal inquiry. Some of them, especially among men, indicate knowledge gained from media, school, friends and community education sessions; and the unique opportunity of pre-marital learning because of delayed marriage.

"I knew about the methods before getting married. I learnt while working as a volunteer and housemaid. I was educating people about pills and how to use them." – a woman currently using contraceptives from Herat province IDI516

"Prior to marriage I had a little information about the methods. My mother had many children but not good life. We were getting information from radio and television." – a man currently using contraceptives from Bamyan province IDI836

"I knew about injections as my cousin used it, and it generated problems for her." – a woman currently using contraceptives from Kabul province FGD611

"I had some information regarding the family planning methods before marriage. I was asking what they are used for, and the answer was: protection from unwanted pregnancy." – a woman currently using contraceptives from Herat province IDI512

"I knew about condoms before getting married. The CHW was doing community education and telling us about the different methods." – a man not currently using contraceptives from Khost province IDI942

"I knew about family planning methods before marriage because I married when I was 40 years old. I was able to get information from my friends and other people I met." – a man currently using contraceptives from Herat province IDI513

"I had studied about the methods at school but that was not enough knowledge. We were told that the people will be informed about it after getting married." – a man not currently using contraceptives from Kandahar province IDI741

A number of respondents indicated experiences of living in other countries (e.g., Iran and Pakistan), and learning about birth spacing methods from there. This may be a reflection of the greater availability of information about birth spacing methods as part of more established birth spacing promotion and service provision. However, some also attributed their lack of awareness to such experiences of life in Iran. This may be a reflection of missed opportunities for displaced people to benefit from the systems and services of a host country.

"In the past I have lived in Iran and got information from there." – a man currently using contraceptives from Herat province IDI535

"We don't have any information about birth spacing because we were in Pakistan and we were very poor. In the morning we would go for work to find some food for our family, and would return home late in the evening. We had no time to learn about such things." – a man currently using contraceptives from Kunar province IDI132

"When we lived in Iran these things were not available at all. We lived there for 14 years. When we came to Afghanistan in the government of Taliban; the methods were not available then." – a woman not currently using contraceptives from Herat province IDI525

Current awareness about birth spacing methods

The discussions by respondents with regard to current awareness of birth spacing methods were largely focused on a narrow range of methods as provided by two elements of what can be described as the 'modern health system:' free government health services and the private healthcare market. A few respondents reflected awareness and use experience about what was described as 'natural methods';¹⁹ used in reference to fertility awareness

¹⁹ This covers methods that do not require any (or significant) use of manufactured (non-natural) materials; and thus almost entirely use-driven and controlled. The main role of the health system in 'provision' of such methods is in: a) recognition and categorization as legitimate birth spacing methods; b) inclusion in the training and standards of practice in the health system; and c) due coverage in the process of delivering birth spacing services (e.g., through counselling, awareness raising, multi-media promotion, data collection and reporting, etc.)

methods (primarily calendar approach), and to withdrawal method. Although the pregnancy prevention benefits of breastfeeding are recognized (as presented already in Section 3.1.3 and 3.1.4); the lactational amenorrhea method was not explicitly indicated or discussed in-depth as a known and used birth spacing method. The dominant perspective among respondents is distinct difference in the extent of awareness about two broad groups of birth spacing methods:

- A. Greater awareness about methods that are available within easy reach to the users; at what can be described as the primary level of the health care system. This included methods delivered by volunteers at community or household level, available as an integral element of the services at local government health facilities (referred to by many respondents as 'clinics'); and the methods available in the nearest large town in large public health facilities, private hospitals and other categories of private health care facilities, and in private pharmacies and other sale points for medicines and the more openly available health commodities such as condoms. This covers most of the short-term methods (Pills, condoms, injections), but did not clearly include lactational amenorrhea method, fertility awareness methods and other natural methods.
- B. Lower level of awareness about methods that are more difficult to access – usually available in more distant big cities and larger or more specialized hospitals within the country or outside (e.g., in Iran or Pakistan – as mentioned by some respondents). Access to such methods is associated with greater cost in terms of travel, direct service costs, etc. Most of the long-acting reversible contraception methods (e.g., IUD, implant) and the permanent methods (tubal ligation, vasectomy) were discussed in this category.

"One day I went to the clinic and I saw a chart teaching about injection and condom. I know only about those two methods." – a man not currently using contraceptives from Samangan province IDI 443

"We don't have information about birth spacing methods; but the women might have the information. Whenever our women go to the health facility they get information. But when they return home, they forget all the information." – a man currently using contraceptives from Kabul province IDI636

"About long term method I do not know but when my son was born in hospital, the midwife told me: you should use this long term method. About the advantage and disadvantage I do not know because I didn't use it." – a woman currently using contraceptives from Bamyan province FGD812

"I have read a bit about sterilization in the book. We heard from radio about the methods used by men and women. I also have information about tubal ligation and IUD." – a man currently using contraceptives from Bamyan province IDI832

"I know about the long-term methods. Years ago these methods were in India, but now they available in hospitals and in the city but not available in the clinics." – a woman currently using contraceptives from Badghis province FGD212

"I have no information about the family planning methods, but my wife can use a method if she agrees to use. I have heard people say that IUD is very dangerous." – a man not currently using contraceptives from Kabul province IDI646

"In our village there are women who did operation, and some are using IUD. What I have not heard about is any man doing sterilization." – a woman currently using contraceptives from Bamyan province FGD812

Scope and depth of knowledge about birth spacing methods

The study results reflect that the current knowledge about birth spacing methods is largely based on personal experience of engagement with and use of the methods, and on interaction with other experienced users. In a few situations, there is knowledge reflected about birth spacing methods that does not have direct relationship to method use; mainly gained from media-based promotion of methods. It is notable that most of the issues discussed by respondents that reflect knowledge of birth spacing methods dwell on problems experienced or feared in relation to the use of different methods, and less about the benefits. The perceived problems with use of birth spacing methods appear to be of major concern, especially with regard to the following elements:

- ◆ Reduced ability to perform regular tasks – especially related to IUD and lifting of weights; implant and ability to use the affected arm
- ◆ Effect on menstruation – regularity of cycle, volume and duration of periods; more concern about reduction and its implications with respect to future fertility.
- ◆ Health complications as a result of using some methods, which may require specialized and often very expensive treatment

"I used pills and they gave me trouble. They made me crazy; I reached the stage that I wanted to cut off my child's head. I even became pregnant. And in the end I got no remedy; the doctor thought that this is from my own system and not because of the pills." – a woman not currently using contraceptives from Herat province IDI521

"The tablet is harmful for some people. It causes them headache, pain in legs, backache and losing temperament. Some people who use IUD, say it causes more bleeding in monthly menstruation. Some people who insert capsule (implant) in their arm, say it causes cancer. The best methods are condom or the natural one. My son is using condom. One of my daughters uses natural method; the other one is using tablets." – a mother in law from Herat province IDI552

"When a woman comes to me, I would tell her don't use injection method, as it has side effects and is harmful." – a woman currently using contraceptives from Khost province IDI915

"The benefit of birth spacing methods is very low, like 1%, but the disadvantages are many. Some methods make women become too fat. The IUD is good for using because it is for short time but surgery operation is for all life, my sister did surgery operation now she cannot give birth and she is unhappy." – a man not currently using contraceptives from Kunar province IDI125

The discussions of some respondents reflected inaccurate attribution of health problems to specific birth spacing methods. In a few cases, there is awareness of other factors that could explain such problems that may be experienced alongside the use of birth spacing methods but are not directly attributable to the methods.

"Our neighbor has ligated her tubes and she cries all days. She has also pain in her stomach and it made her blood pressure high." – a woman not currently using contraceptives from Herat province IDI521

"I did not use any birth spacing methods but my neighbors who are using IUD are complaining about backache, sore feet, and not able to do heavy works." – a woman not currently using contraceptives from Badakhshan province IDI324

"People often condemn a person who is using birth spacing methods. If her child is born abnormal, people say it is because of the methods." – a woman not currently using contraceptives from Kabul province FGD622

"I was using pills and injection, and they caused problems such as headache and nausea. But I am not sure if these problems were because of the methods, or stomach problems, or the miscarriage I had." – a woman currently using contraceptives from Herat province IDI513

"I feel pain on my leg and backache; some people say that it is because of the injection. But I think it might be due to the heavy work I am doing." – a woman currently using contraceptives from Herat province IDI516

The discussions on perceived benefits of birth spacing methods is largely limited to prevention of pregnancy and absence of side effects; and other general benefits of birth spacing (child care and nurture, etc.). Condoms were particularly commended in this regard by all categories of respondents as being free of major side effects. Some respondents note the unique benefit of injectable contraception (in contrast to tablets), since it does not need daily reminder and thus it works better because it is not forgotten. Other respondents were explicit on the benefits of IUD as a long-term method compared to other methods that are short term, and also having relatively fewer side effects. It is noteworthy that a number of respondents indicate that weight gain is perceived by some as a benefit from using certain methods, while others recognize this as a problem.

"I have planned to use IUD, as it has no side effect and it works for long time as compared to pills and injection."
– a woman currently using contraceptives from Khost province IDI916

"The IUD has fewer problems than tablets and condoms. When I went to the midwife, she told me that I will have some spotting of blood for the next six months. Luckily I did not face such a problem." – a woman currently using contraceptives from Herat province IDI515

"I use pills, and they do not have much side effects; I am happy with this method. I can do my housework and have enough time with my children." – a woman currently using contraceptives from Herat province IDI511

"The condom is easy to use, clean and has no side effects. I have used it for years and I have never experienced any side effect." – a man currently using contraceptives from Herat province IDI536

"I have this intention to change our current method with the implant method which is inserting in the arm's muscle. We heard that this method hasn't side effects so we want to use this method." – a man currently using contraceptives from Kunar province IDI135

Many respondents reflect knowledge about the different steps in the process of accessing birth spacing information and the actual method provision. They highlight elements such as:

- A. The need to get information from multiple sources (e.g., health volunteers in the community, health professionals at the facility, people with experience using certain methods, etc.)
- B. The importance of dialogue with others (especially in the family) in considering use of the methods and choosing the specific method to use
- C. The need for medical checkup and assessment before commencing use of birth spacing methods.
- D. Recognition that some people with specific health problems should not use certain birth spacing methods. However, there is limited attention to the need for continued follow up and assessment over the period of method use especially in dealing with experienced problems.

The unique needs related to use of birth spacing methods during the period after delivery were discussed at length by respondents but the perceptions of many of the respondents reflected limited knowledge and elements of mis-information. The common perception is that use of birth spacing methods is only appropriate after at least 40 days following the previous delivery. Some respondents indicated that consideration of methods use is most appropriate after return of the monthly menstruation. Such views are likely to result in missed opportunities to start using appropriate birth spacing methods in the immediate post-partum period, and possible unplanned pregnancy.

"In my opinion after 6 month of delivery the couple should use because after that maybe the menstruation of woman will start and also the menstruation of some women start after 40 days of delivery, therefore such women should use after 40 days of delivery." – a woman currently using contraceptives from Bamyan province FGD812

"I do not use because I am breastfeeding my baby who is only 7 months. There is no need for contraception at this stage. Before I got pregnant I was using and I was healthy. My trainer told me that during breastfeeding my child I will not need to not use contraceptive method." – a woman not currently using contraceptives from Herat province IDI524

"If menstruation returns before 6 months pass, the woman should go to the midwife for advice and be given the right birth spacing method." – a woman currently using contraceptives from Bamyan province FGD812

There is recognition of close association between breastfeeding and contraceptive use, with respect to the delayed return of monthly menstruation as a result of breastfeeding, and the negative impact of some birth spacing methods on the effectiveness of breastfeeding. A few respondents have knowledge about the specific methods that are safe to use even in the early post-partum period, including IUD, condom, and what was referred to by some as breastfeeding pills. However, there is inaccurate attribution of contraceptive value to the practice of breastfeeding for as long as it lasts. Some respondents highlighted the value in use of birth spacing methods in effort to protect sustained breastfeeding until the full period of 2-3 years as recommended in Islamic teaching.

Current and past sources of information on birth spacing methods

There are two main categories of current sources of information about birth spacing methods as used by respondents:

- A. Community-level sources that include people with experience using the methods, and community members that have received specific training to provide information and supply methods (mainly FHA group members and CHWs); and
- B. Health facilities – as one area of frequent focus in group education sessions, and through specific consultations for birth spacing services.

The popularity and frequency of utilization for these sources is closely linked to three main parameters: i) ease of access and frequency of contact between them and the women or men needing the information; ii) their perceived knowledge or expertise with the method – based on experience using it or specific training received about its use; and iii) social relationship between them and the women or men in need of the information. Many respondents indicated experience of concurrent or sequential access to multiple information sources, based on incidental or deliberate contact opportunities, cross-referrals for more information, and consultations for joint decision-making.

“The best way to inform about family planning method is to discuss it with each other.” – a woman not currently using contraceptives from Bamyan province IDI826

“You first get information from people in your home and if that is not possible then the hospital is the best source. The hospital is better because it is so clean and neat and also good for both mother and child.” – a woman not currently using contraceptives from Bamyan province FGD821

"The information is available in the clinic when women go there for services. When one woman gets aware, then she passes the information to other women." – a woman not currently using contraceptives from Kabul province IDI623

"We get the information from CHWs, if the CHWs are not available we get it from the clinic." – a woman not currently using contraceptives from Bamyan province FGD822

"Firstly they [people who need birth spacing methods] have to get information from those people who have already used the methods, then go to the health centers." – a man currently using contraceptives from Bamyan province IDI836

It is notable that many women indicate that their husbands are an important source of information on birth spacing methods, based on their literacy, more opportunity to move outside home and access external sources for such information, and greater access to media and to other sources of such information. Similarly, a number of married men indicate their wives as a source of such information, because they are often more informed about birth spacing methods through their more frequent interaction with health facilities and with community-level health volunteers.

"I got the information about birth spacing methods from my husband; and he got the information from health facility and doctors." – a woman currently using contraceptives from Kandahar province IDI711

"I get information about birth spacing methods from books. When women go to the clinic for vaccination, they also get information about birth spacing." – a man currently using contraceptives from Kabul province IDI635

"My husband is a teacher; he brings information and encourages me a lot about use of the birth spacing methods." – a woman currently using contraceptives from Jawazjan province IDI013

"The best way to inform people is radio and mosque because the males will get information and they will tell to us." – a woman not currently using contraceptives from Kunar province IDI126

Health professionals are especially seen by most respondents as a critical source of information on birth spacing methods at two main levels: i) as social associates that have unique ability to explain many details about the different birth spacing methods and their side effects; and ii) in their professional role as they guide users in the process of health assessment and choosing the appropriate method to use. It is notable that only a few respondents indicate health professionals as major sources of information when considering and making decision on change of methods.

A few respondents (mainly men) mentioned use of other sources of information such as media, Mullahs and schools. It is notable that a number of women commended these as important sources information especially for young people, although they acknowledged limited personal access and utilization of such sources.

"We get information from community health workers and from the clinic. Furthermore, we hear from radio and TVs. Our mosque's mullah does not know about it, otherwise he would inform us." – a man currently using contraceptives from Bamyan province IDI832

"As I'm a religious scholar, I advise people to use birth spacing methods which they are already guided through clinic, CHWs or health post. We focus on methods such as condoms which have no side effects. We also advise the mothers that they should breastfeed their children for two years to delay the next pregnancy. This is very important nowadays because many women get married when they are still very young and they can get many children; some die in the process. The doctor gave us information about IUD but no one told us about its side effects; It may not have any side effect." – a man not currently using contraceptives from Kunar province IDI144

"Like polio campaign, they should go home to home and give information and advice on birth spacing methods to those who are illiterate and live in homes." – a private pharmacy staff from Kandahar province KII755

Ideal sources of information on birth spacing methods for adults and young people

In their discussions on ideal sources of information on birth spacing methods, most respondents indicated health professionals and community-level health volunteers (categorized by some respondents as people with enough knowledge and expertise) as appropriate; delivering the information at health facilities and in community-based group settings (health education sessions, places of worship, home visits, etc.) and through individual counseling and dialogue sessions. Other sources highlighted as ideal were: electronic media (TV, radio), family members, and dialogue with persons with experience using the methods.

"Information about birth spacing methods should be communicated through religious scholars because people listen to them. Social media is also a good option to spread awareness about family planning methods to young people." IDI224

"Those who want to know about birth spacing methods should ask their neighbors and then they should visit doctors to take counseling." – a man currently using contraceptives from Jawazjan province IDI031

"The best way to give information on birth spacing methods for a knowledgeable women like you is to visit villages and educate people. When I see such information on the television of my relatives or neighbors, I am encouraged to have fewer children. It is important that such information should be delivered through mosque so that my husband can get aware about it and bring it to us." – a woman not currently using contraceptives from Kunar province IDI123

"We visit the midwife and get info about birth spacing from her, as she is also a lady. This is the best source of information." – a woman currently using contraceptives from Bamyan province IDI816

"It is good that female CHWs provide information to women, because there are men whom we can not talk about methods. I gained most information through my wife who is in contact with the CHW. So it is easy for me to get information from my wife, as some people have negative minds." – a man currently using contraceptives from Herat province IDI533

It is notable that a number of female respondents indicated media as the ideal source of information, although none mentioned media as the current source. As expected, these tended to be the ones with some level of education and younger in age. A quantified analysis of the indicated ideal information sources for youth is presented in the graph below.

"The best source of information is the clinic. Women who use these methods should share their experience with other women to inform them." – a woman not currently using contraceptives from Bamyan province IDI823

"It is best to get the information from clinics and the CHWs. The CHWs are better because they go deep into the villages and educate people there. Clinics are far, and some people cannot go there." – a man currently using contraceptives from Herat province IDI536

"People should go from villages to the health clinic and get information. No one learns something by just sitting at home." – a woman not currently using contraceptives from Herat province IDI522

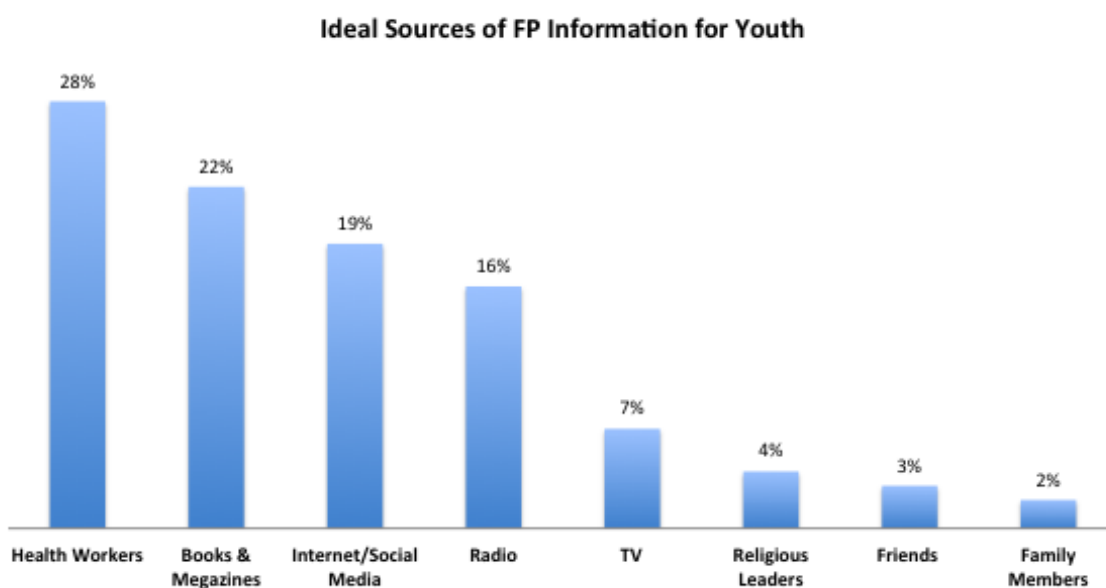
"In my opinion, information should be delivered through health facility, radios, TVs and internet. Similarly, publicity campaigns should be made in villages." – a man currently using contraceptives from Kabul province IDI631

"If it is broadcast on TV it would be better because everybody have TV in their home. If somebody doesn't have TV maybe someone with a TV will watch it and tell him about it." – a man currently using contraceptives from Kunar province IDI132

"In my view, the best way to inform people is through television and through talking to each other. Whenever two women meet, they usually talk about contraceptives." – a woman not currently using contraceptives from Herat province IDI523

"It is good to get information through TV and media. The TV is available everywhere and people like to watch it." – a woman not currently using contraceptives from Herat province FGD521

Figure 6: Perceptions on ideal FP information source for young people



Inclusion of FP information in school curriculum

There is overwhelming support among the female and male respondents to the idea of including FP information in the school curriculum. The reasons stated for this support were in three broad categories: a) schools that are distributed in all villages and attended by most children as an effective channel to reach many; b) the opportunity to enable children prepare early for their own family life and child bearing; and c) children as an effective means to get information to their family members and the broader community.

"It is a good intervention if information about birth spacing methods is included in curriculum of schools. The students will become familiar with these methods and they will inform their families and neighbors about it." – a woman currently using contraceptives from Badakhshan province IDI316

"It is good that girls know about it in school and get awareness early. For me I did not get education and knowledge of using methods; I only know my prayer. We lived in the village and we are illiterate people." – a woman not currently using contraceptives from Herat province IDI526

"Yes the FP information should be given in schools. Nowadays girls and boys go to school; they can learn and pass the information to their families ." – a man not currently using contraceptives from Herat province IDI531

"Including family planning information in the schools is good idea. Thank God nowadays there are some educated persons in every family to inform others." – a man not currently using contraceptives from Kunar province IDI143

"It is better to include the family planning methods in schools curriculum. My youngest daughter will teach me." – a woman currently not using contraceptives from Kunar province IDI124

Some respondents attached conditions to such support; including: a focus on older children (13 years and above); ensuring that the teaching is gender-specific (female teachers to girls and male teachers to boys); and a particular focus on girls as most needing such teaching.

A number of respondents were not in support to the inclusion of family planning information in the school curriculum; more among the respondents not currently using contraceptives (8 out of 112 responding on this) compared to those currently using the methods (only 3 out of 118 who responded). Reasons given for this position include: many children remain out of school and will not be reached; girls in school will learn too

early about things meant for women and may misbehave as a result; it will decrease the population of Muslims; and boys will be exposed to 'women's secrets'. It is remarkable that in one FGD with women not currently using birth spacing methods, all participants were unanimous that including such information in the school curriculum is not a good idea.

"Only one out of a hundred people are educated; the remaining people are all not literate. My son and daughter do not go to school because of my husband; they only go to learn Quran. Some families are educated but all others are illiterate. The good way of learning these methods is from television." – a woman not currently using contraceptives from Herat province, IDI521

R1: "No, our boys will know about this."

R2: "No, boys will know about everything and will become rude."

R3: "No, It is not good."

R4: "No, because boys and girls go to school and they will become impudent/rude."

R5: "Children are unwise/not mature; it is not good for them to learn these things."

R6: "It is not good; they are children and should not understand these things."

[women not currently using contraceptives from Herat province FGD521]

"I think it is not good to study family planning in schools they are not mature enough to know these issues." – a man currently using contraceptives from Jawazjan province IDI034

"Family planning should not be included in the syllabus of Madrassas and schools. The reason is, no one can use properly these methods and they would use it in the wrong way. Also human behavior would damage from such initiative." – a man currently not using contraceptives from Kabul province IDI644

3.1.6 Couple experiences of using modern contraceptives

The use of birth spacing methods reflected in the study results are closely aligned with the perceptions and experiences as already discussed in section 3.1.1 to 3.1.5. In general, discussed utilization of birth spacing methods is largely limited to three short term methods: Pills, Condoms and Injection; and to a less extent IUD as the main long term method. The text box below presents a case example to illustrate key method use experiences; including:

**Text Box 2: The lived experiences of a User – A case example
(20-year old woman, married for 6 years, has 2 children - 1 male, 1 female)**

I knew about the methods before getting married when I was working as a volunteer and house girl. I was educating people about tablets and how to take and use them, mainly by showing pictures.

At first, after getting my first baby, I was using tablets for five or six years. I prevented my pregnancy for five years. I consulted with my husband, he said go and take contraceptive method. We get the method from the clinic or from the CHW house; we get it from the place where it is available. If it is not available with the CHW, we go to the clinic. The clinic is better. We come here, and the midwife helps us by solving our problems. , She gives us injection and we bring it to house and anyone having the skill then injects us. We are feeling good and comfortable here. We get it free of cost, but private pharmacy asks for money. Whenever we go there [to the clinic], we get the tablets and injections in stock. If they were not available we get it from the CHW house.

The services at the clinic are good. Sometimes when we go there we wait long to visit the doctor. Sometimes they are good and we wait for less time. If they have medicine they give it to us after checkup. They give advice to us and tell us when you become sick, take care of your children and don't use medicines on your own desire. They give us health information and then we share it with other members of the family.

The only problem is that the clinic is far away, about 20 minutes away. We go there by walking. The vehicle is not available and we go by foot and become tired. I go there sometimes with my husband's sister and sometimes with mother in law. Because they are from my family and my relation to them is close. My mother in law often tells me to go together with her.

I was using tablets and sometimes I was taking it on time but sometimes with one or two minutes delay. My body was not consistent with tablet and it caused me sickness. I was facing dizziness, headache, and I was facing menstrual cycle two or three times in a month. I decided that tablet is not good for me, and tried injection. I decided I was forgetting to take the tablets on time and this was causing sickness to me; so I started using injection and see what will happen. My husband also told me go and take injection to prevent pregnancy because more children are not good and we cannot maintain services for them. In my family I was encouraged to take injection as I forget taking the tablet on time.

When for the first time I took injection, I became sick for a complete week and I was told that I am too young. Two or three times it caused dizziness to me and I was not able to stand. My mother in law told me sit and take some rest. The entire week I was facing bleeding and was not able to sit. When after three months I took another injection I was stopped to use this method because I was underage. Now I am facing problems. I have pain in my legs, I cannot get up from my bed and cannot sit; but still I am taking injection. I also suffer from backache, people say it is because of injection but I think it might be due to heavy work I am doing.

I don't know if I will change the method; I want to continue the injection method and see what happens. Because I don't want to have more children, it is difficult to raise children. I don't want to be pregnant for three or four years and will see later if I want another child. I feel happy to use birth spacing methods; I don't feel guilty. It is good that I will not give birth and enjoy life, maintain services for children. That is why I use injection and feel happy. In Afghanistan there are many problems, parents cannot afford children needs so I want to prevent pregnancy for two or three years.

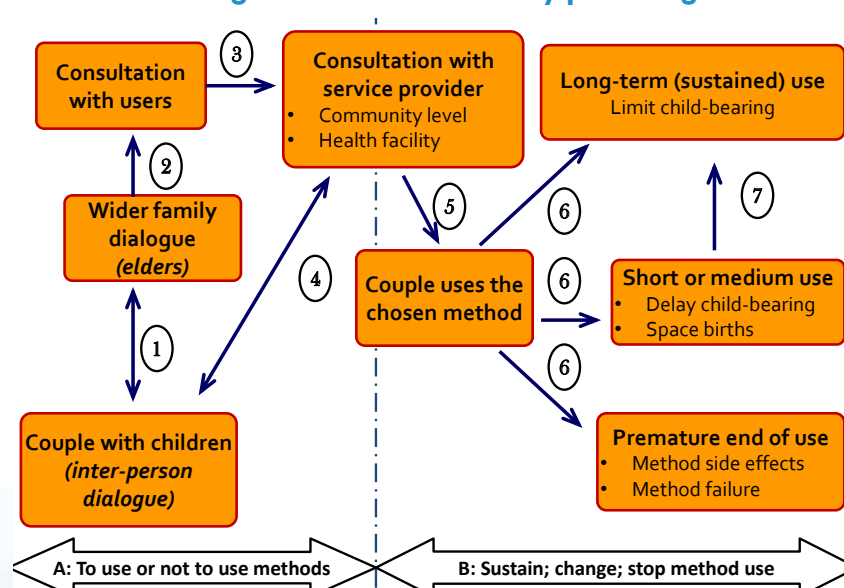
- ◆ The opportunities to access information about birth spacing methods before marriage
- ◆ The imperative of dialogue and joint decision making by wives and their husbands
- ◆ The supply-side parameters that influence access and utilization of contraceptives
- ◆ The experiences and coping approaches with side effects of contraceptives
- ◆ The motivation and determination for sustained method use despite challenges

Decision-making process about use of birth spacing methods

The decision making process about use of birth spacing methods as reflected in the discussions by respondents is presented in the flow chart below. It includes six key steps presented in the chart as a sequential process; with one additional seventh step for some people. The experience in practice is more of an iterative and cyclic process; and may include skipping some of the steps. This is illustrated in the flow chart by the bi-directional arrows at step 1 and step 4. In general, the process of decision-making appears to take place in two distinct phases:

1. Phase A: deciding whether to use or not to use birth spacing methods; and the specific method to use (in the first four steps); and
2. Phase B: deciding on sustained use of birth spacing methods; whether and when to change the specific method in use; or if to stop using the methods (in step 5 to step 7).

Figure 7: Decision-making flow chart on family planning use



Step 1: Dialogue within the family

The contemplation of birth spacing method use as discussed in the study appears to be restricted to a couple that already has some children, and is experiencing problems related to the life and wellbeing of the children or their mother. This is also critically influenced by the family coping capacity; largely based on what the husband is able to generate and provide in form of family sustenance, income and leadership wisdom. As discussed in Section 3.1 and 3.2, the initial consideration and dialogue may be internal to the couple, or may be prompted by someone else in the extended family – usually the mother of the husband.

The process of dialogue and engagement at family level (within the couple and with elders and other family members) may be drawn out and cyclic. If there are experienced users of birth spacing methods in the family, these are often important actors in this dialogue. On the other hand, experienced users outside the family may be included in the dialogue. This may include experienced users with specific health-related training and volunteer responsibility such as FHA group members or CHW.

"My husband is the decision maker and he is preferring me to use injection My mother in law is also telling me to use injection as she believes that the reason behind my miscarriage was using pills irregularly. But from mutual understanding, my husband and I have decided to use pills." – a woman currently using contraceptives from Herat province IDI513

"I am in hesitation; sometime I say let's get the method, then my husband says it would have negative impact on me. Therefore, I am afraid of its harms, therefore I don't go to doctors." – a woman not currently using contraceptives from Kabul province IDI622

"I consult with my wife but my wife should consult with my mother too, because if she doesn't consult with her mother in law she will be unhappy with her." – a man currently using contraceptives from Kunar province IDI134

"First of all a woman that wants to use the methods should discuss it with her husband and after that visit the health facility and take the recommended method which should be prescribed by the midwife according to her health status and choice." – a man currently using contraceptives from Bamyán province IDI835

Step 2: Community-level dialogue beyond the family

Consultation with non-family actors in the community for advice is often a next step taken with family agreement, or may be a direct effort of the couple alone as discussed above. This will often include social associates considered knowledgeable on birth spacing. Such knowledge may be based on personal experience (e.g., as users of birth spacing methods), or on specific training and expertise (e.g., as gained by trained health volunteers or health professionals). For example, a midwife may be consulted at home for such advice, and in some cases she may provide the method from home. It is also with this consideration that religious scholars may be consulted at this level, especially with regard to the religious interpretations and implications of birth spacing methods.

"Two women in my neighborhood use family planning methods and I consult with them. I also consult my husband and my sister in law. I go to the clinic with my sister in law and get method from there." – a woman currently using contraceptives from Kabul province IDI616

"First they have to get information from those people who have already used the methods, then go to the health centers." – a man currently using contraceptives from Bamyan province IDI836

"I always consult with my family and neighbors about birth spacing methods. After consultation with them, I contact the midwife to get the method." – a woman currently using contraceptives from Badakhshan province IDI314

"It is necessary for women to make decision with their husbands, and they should go to health facility or doctors with their husbands. The doctors also give the methods on consent of both husbands and wives, and then the methods are given out by the midwife." – a man currently using contraceptives from Khost province IDI931

Step 3: Consultation for services

This step often comes once the couple is convinced about the value and safety of taking on birth spacing methods, and possibly has a focus for possible methods to use. This consultation may be with a CHW who provides methods at community level, or at a health facility. In some cases, it may be a visit to a pharmacy or another medicine sale point to purchase an already decided method.

"First they should tell to their husband at home and get his permission, then she should go to the clinic in order to have medical examination, and should use these methods." – a man currently using contraceptives from Bamyan province IDI833

The first birth spacing consultation at a health facility is most often accompanied by a family member or a community resource person (FHA group member or CHW). One of the key reasons for such a consultation to be with the appropriately qualified health provider is the need for assessment of personal health status and its match to the right method. The discussions by many respondents reflect a need for women seeking birth spacing services to go together for mutual encouragement and support, or to be accompanied by male relatives as a social norm and/or a mechanism for protection in circumstances of insecurity.

"The health facility is about two kilometers from our home; the cost of public transport there and back is 20 Afs. There is no need to be accompanied there as the security is good and the doctors are good in providing services." – a man currently using contraceptives from Herat province IDI535

"Since there is no road for cars to our village, I come to the clinic by walking. I always come to clinic with an accompanying person. We are living in village if I come alone they will say wrong things; so I usually come with my husband." – a woman currently using contraceptives from Badakhshan province IDI313

"The clinic is about 20 minutes away from our home on foot. We come by foot and we aren't paying transportation cost. My brother in law's wife is accompanying me whenever I come to the clinic." – a woman currently using contraceptives from Samangan province IDI413

Step 4: Validation and confirmation of method choice

This step is largely necessitated by: a) the need to reflect and arrive at an 'informed and voluntary' choice of method; and b) the need to share the decision-making process with others that may not be included in the 'consultation visit.' In some cases, this may be an on-site consultation and dialogue, e.g., with the accompanying mother in law or husband who may have been waiting outside while the method education and counseling takes place with the wife alone. Some of the providers indicate that the need to confirm consent of the husband makes this step a requirement, especially for provision of long term or permanent methods.

"My husband told me that do not use contraceptive, because I was weak and I had stomach disease and low blood pressure and it was harmful for me. He says give birth to third daughter then I am free to use the contraceptives. I have no permission to go and use contraceptive until I give birth to another daughter." – a woman not currently using contraceptives from Herat province IDI523

"One of my daughters in law used the IUD when she went to the city. But her husband got too much angry with her. Now she is going back to the midwife to remove the IUD." – a mother in law from Herat province IDI554

"Some people don't like to use the methods. In our village our Imam's wife has a 2-year old child and she is already pregnant. She had IUD but she went to the city and got it removed, because her husband said that it was a sin. Now she has many children." – a woman member of an FHA group from Herat province FGD542

Step 5: Starting method use

The dominant perception is that method starting is by and large on 'trial' basis; to use the method 'for some time' and see what happens. In general, there is limited clarity about the structure, progress milestones and indicators, and duration of this trial period. Many of the use experiences discussed seem to reflect that:

- A. Decision about these critical parameters is often made by the user, with limited structured guidance and support from service providers;
- B. There seems to be limited distinction between method use experiences that are expected and acceptable as part of the process of 'adjustment and getting used' to the method, and those that are clear signs of problems that need further guidance and help or discontinuation of the method;
- C. There is little or no consideration of the medium and long-term intentions and expectations with respect to method use (e.g., the ultimate objective of method use, at what point that objective gets achieved, what happens after the objective is achieved, etc.)

The method use experiences of most respondents reflect a virtually exclusive focus on this step as the sole purpose of family planning services: the enrolment of married women or couples as method users. There appears to be limited structured guidance and support to the decision making and experiences of couples after they start using methods.

My mother in law and brother in law's wife told me to use pills for one month, in case if it created any complications then I should stop the method." – a woman currently using contraceptives from Herat province IDI512

Step 6: Decision making and action after method start

During and after the period of 'trial use' a couple continues to be faced with key decisions and action options, based on their ongoing use experiences. The experiences in this process as shared by respondents can be clustered into three main categories:

- A. Long term or sustained use of birth spacing methods – mainly by couples that have completed child bearing. This includes decision on use of permanent and long term methods; and on method change to these options for couples that initially start with short term methods (represented in the flow chart as step 7)
- B. Short or medium term use of methods – mainly to space births or delay initiation of child bearing. This may be for a pre-determined period, for example use by a wife still completing a period of education or training, or use for two or three years between births. In some cases, it may be for an extended period of undefined duration, with the decision to stop use to be made at a later time.
- C. Premature termination of method use – largely based on negative experiences with method use, including method side effects; unplanned pregnancy attributable to method failure; social pressure to stop use from spouses and other family members, etc.

"It is a good feeling that I prevent pregnancy. I have a daughter in law and grandsons; it would be a great shame if I give birth at this age." – a woman currently using contraceptives from Herat province IDI514

"We will use the injection method until our first child is about two years. We have six more months." – a woman currently using contraceptives from Khost province IDI914

Many of the older study respondents (mainly men above 40 years and women above 30 years) have what they consider to be adequate (or even excess) children (usually 5 or more), and do not want to get any more children. However, most of them use short-term methods; primarily Pills and Condoms, some on injections and a few using natural methods. Among them are many who have used such short-term methods for some years; often changing from one method to another because of experienced problems.

"I use it since three years. At first I was using tablets, it caused headache and it increased psychological problems that I had before. Then the doctor said to use the injection, it increased the menstrual bleeding, and it cause me swelling, then I left the method. now I am careful about it and take special precautions. I was using tablet each night.

One night I forgot taking the tablets and I got pregnant. When my daughter born, she was very weak. I have heard about medical operation, I said I would do medical operation, but my husband will not allow me." – a woman currently using contraceptives from Kabul province IDI612

Some of the respondents indicate use of birth spacing methods to achieve a temporary halt in child bearing, with an open possibility of getting a child later on. It is notable that many of such users indicate having some children considered an adequate number (2 or 3), and have both male and female children. They also tend to be in their 20s. It is noteworthy that the few current users of long term reversible methods (IUD, implant) belong to this category.

"I am not ready now. If I could I want more children in the future. Now I want my children to grow well. In the future I want to have one more daughter and son." – a woman currently using contraceptives from Herat province IDI515

"Yes, I want to stop as my younger child is about 3 years old and I want to give birth to another child." – a woman currently using contraceptives from Kunar province IDI112

"As my wife has been operated and her uterus is removed so we don't use any methods." – a man not currently using contraceptives from Kabul province IDI643

"Some people prevent pregnancy until 3 years. When they stop using contraceptive methods they will be pregnant in 6 to 7 months. It is good to use family planning methods. Some people like to take space between children up to 7 years." – a woman not currently using contraceptives from Herat province IDI523

"I used birth spacing method; that is why my daughter was born later. The space between two pregnancies should be 3 to 4 years. My son is now 10 years old and the other one is 3 years old." – a woman not currently using contraceptives from Herat province IDI526

Many of the younger respondents, with fewer children and longer spacing between births indicate experience and current intention of using the methods to manage the spacing of their children. They usually have a clear perspective of the number of additional children they want, and the reasons why they want them – usually related to achieving sex balance in their children.

**Text Box 4: Use of contraceptives for birth spacing – A case example
(35-year old woman from Bamyan province FGD 812)**

In my opinion a couple should have 3 children because they can provide them everything very easily. The issue of boys and girls belongs to Allah.

Nowadays it is good because women are using birth spacing methods. People are think the husband and wife who have fewer children are a good couple because they can provide them food and clothes. Also they can send them to school, up to university. But if they have more children then they will face problems. I can also say that few children are better for the future.

I consult with my husband and mother-in-law and after permission from them it will be very easy to use birth spacing methods. Some mothers-in-law like grandchildren and without her permission I cannot do anything. We discuss about the health of mother and the health of children. The health of the mother is important; if a mother doesn't have good health she cannot take care of the children.

The birth space between two pregnancies should be 4 years. If a mother gives birth after one year or two years, she and the children will be not healthy. In our village the period of birth spacing is 3 years. Now my daughter is 3 years and my youngest son is two month old; because I was using birth spacing method. I use the birth spacing method which is good for mother and child health.

Before that the family faced many problems. I didn't know about family planning methods before my wedding. It was after marriage and getting two children that I got information and started using the birth spacing methods. The health worker stay near to us and I get it from her. In my opinion clinic is better because first you should complete your checkup and then you will get the medicine.

The use of birth spacing methods to delay child bearing is rare among the study respondents; articulated by only two married men. This represents an important opportunity for service growth potential.

"My wife is a student and still needs to complete her studies and graduate. That is why we are using pills; which she has been taking each night. My wife first suggested this, then we discussed it together and we reached a consensus to use the method." – a man currently using contraceptives from Badghis province IDI236

"We are not using methods at the moment since we have children, but we were using injection before when we had no children. When we got married I did not want to have children very soon, so I went to the clinic and they counseled me." – a man not currently using contraceptives from Khost province IDI944

A number of study respondents, most of them included under the category of those not currently using contraceptives, indicate current or past experience and specific effort to space births using natural methods. Many among these mention breastfeeding for the full duration of two years as the main action taken that enabled appropriate birth spacing. Others indicate calendar method, and coitus interruptus as the used methods. Long absence of the husband while engaged in work away from home and the providence of Allah were also discussed as forms of natural birth spacing.

"We have not yet used birth spacing methods, because my wife has naturally two and half years birth space. She breastfeeds the children for 2 and half years, and we now have two sons who are well spaced." – a man not currently using contraceptives from Badghis province IDI246

We are using natural (safe time) family planning method. For example after menstruation period is over, if women do intercourse after 10-12 days, they don't get pregnant. There are tablets and injections but they have harmful effects. I was using condoms but they also have harmful effects." – a man currently using contraceptives from Herat province IDI531

"I have not used the other methods for birth spacing; we only used the natural method sometimes because my children were breastfeeding for a long time." – a woman not currently using contraceptives from Kunar province IDI123

Many among the respondents currently using contraceptives are happy and satisfied with their choice to use, and with the specific method in use. The main factors underlying this as emphasized by respondents are: a) the clarity of the purpose why they are using the methods and the benefits they get; and b) the positive experience of using the methods with no or just a few problems that they are willing and able to cope with. However, some among them acknowledge experiencing major problems, often leading to change in method used. Others also indicate facing social pressure and disapproval from family members. A number mentioned problems of guilty feelings because of using the contraceptives which is against Islamic teaching.

"We use pills because the doctor told us that the side effects are minimal. The injection method might cause abscesses, and the condom can easily break. The pill can cause high blood pressure and it might increase the weight. We have been using it since the beginning and the side effects we experienced were for a short time in the starting month; it has no side effects now. It is available in the clinic every time, we do not face any shortages, and it is easy to use. – a man currently using contraceptives from Kunar province IDI131

"I feel happy because for other methods I have to go to the pharmacy to get it. The IUD is implemented once and it is secret no one can see it. I feel comfortable with this method." – a woman currently using contraceptives from Herat province IDI515

The birth spacing methods currently used by respondents are mainly condoms, pills and injection; with some respondents using natural methods, and a few using IUD and implants. Many of the respondents acknowledged change of methods over time, mainly because of experienced (or perceived but not actual) adverse effects. Some respondents acknowledged use of permanent methods for both women and men by persons they know in their community. The limited experience with long-term and permanent methods, costs associated with accessing them, fear of their potential adverse effects, and strict prohibition of permanent methods by Islamic teaching are important limiting factors to their current use.

"I am scared of using the IUD or implant as I heard it is even harder than giving birth to a child. I want to continue with pills. My husband told me to insert IUD, but I do not want and feel shy. After miscarriage, I feel weaker and in public health facility they want us to pay for inserting IUD method up to 250 Afs. Yet it is supposed to be free of cost as it is not a private facility." – a woman currently using contraceptives from Herat province IDI513

"I get it from the pharmacy, I send my 12 years old son to the pharmacy and he brings it to me." – a woman currently using contraceptives from Kabul province IDI611

"We are 10 families in the village, from which 4 families are using these methods. We don't go to the clinic, because the CHW is near so we go there and get the methods." – a man currently using contraceptives from Bamyan province IDI831

"I tell people it is good method, and some have asked where we get this method. I told them from the CHWs or clinic. I tell them that the women get counsel from the midwife; and men from the doctors." – a man currently using contraceptives from Badakhshan province IDI333

A few respondents currently using contraceptives, and some among those not currently using methods, indicate that problems experienced using methods have led them to totally stop contraceptive use. It is evident in the discussions of respondents that the understanding and interpretation of experienced problems attributed to contraceptive use, and the decisions to change methods or completely stop contraceptive use are made by couples based on limited knowledge and hardly any consultation or support from health service providers. Some of them mentioned specific concerns about the quality of services received at health facilities.

"At the moment I use condom. Tablets and injection gave me side effects, but condoms have no side effect. When I used tablets I had severe headache, bleeding and I was getting fat. I changed to the IUD and I paid 1000 Afg because I went to the midwife at her home to insert it. When I was using loop I was happy. That was for 10 years and my monthly period was normal. I got back pain because it was not inserted properly and now I'm using condom." – a woman currently using contraceptives from Jawazjan province IDI013

"My husband used condoms and he faced some side effects and was not able to continue with them. He encouraged me to use another family planning method, and I started using pills. They have given me menstruation problems, I could not take care of my child and house work because of that. The other side effects are sore feet, headache, dizziness, short temper, abdominal pain and nausea. I don't want to use pills anymore because they have too many side effects. Moreover, we cannot afford the treatment cost to recover. The IUD is better as compare to other methods as after inserting you are not able to face unwanted pregnancy. Whereas, IUD also has its own side effects such as, uterus pain, and sometimes it causes unwanted pregnancy. I would want to change the method but I don't like to use implant or IUD. Most of the people are saying that implant has many other side effects and I do not want to use." – a woman currently using contraceptives from Herat province IDI512

"When I took tablets, they caused me backache and bleeding so my husband fought with me and said that why I was destroying myself. He also said: don't use the injection, it is ok children are God given." – a woman currently using contraceptives from Samangan province IDI411

Method sources, costs, and perception of quality

Most of the current users of birth spacing methods get them from public health facilities and CHWs; and indeed prefer to get the methods from these two sources. The reasons given for these method source choices include: easy access (short distance, friendly and same sex providers) free provision of methods, knowledge and expertise of the provider, and confidentiality experiences. In a few cases, respondents indicate getting methods from private pharmacies and other shops that sell methods such as condoms. The reasons given for seeking methods from such places at an additional cost of paying for the methods include: closer location compared to the health facility, and method stock out at health facilities and CHW. Experiences of method stock out are common in either health facilities or with CHW, but usually either place has the methods or there are re-stocked after a few days. Some men users indicated that it is easier to access condoms at the private pharmacy and drug shops, because it is quick and there are fewer people there to know about and question the use.

"I prefer private doctor because there is no load of patients and get it easily a compare to public health facility." – a man currently using contraceptives from Kunar province IDI131

It is notable that some of the respondents currently using injectable contraception indicated that the method supply is given at the health facility but not administered there. This is mainly because the midwife (or any other female staff) is not present to administer the injection. They are instructed to have it administered at home.

"Once I went to the health facility for my next injection and the midwife was not there. The [male] doctor gave me the injection to get it administered at home; he did not even tell me how to use it. I took it and my brother's wife injected me." – a woman not currently using contraceptives from Herat province IDI526

"Some women have the injection come to me and ask me to inject it. Some women have problems with injection; I don't want to inject for them." – a woman not currently using contraceptives from Herat province IDI522

The concurrent utilization of multiple sources of methods as evident in all provinces included in the study presents unique challenges in tracking use rates (e.g., accurate recording of users and their retention, and in processing and reporting/sharing of data).

The costs associated to accessing methods include: transport (mostly around 20 AFG, ranging up to 100 AFG); and purchase of methods in private settings (range 30 AFG to 50 AFG each visit supply for 3 months).

There is a general sense of satisfaction with the services of health facilities and CHW, with regard to provision of birth spacing services and other general services. The parameters of service that respondents are happy about include: provision of adequate information and counselling, inquiry about progress and problems with method use, and careful checkup and provision of medicines as needed. Others are: handling clients with respect, not being angry and violent, building relationship that allows for informal and off-duty contact and interaction, and quick service. Some respondents also attributed the good experience with method used (no or minimal adverse effects) to the quality of counseling and follow up support received from the care providers. However, some respondents expressed concern about crowding at health facilities and informal charges for services at some public health facilities.

"We are satisfied with the behavior of health providers. They have a good behavior with people. They ask and check the patient carefully for better treatment; and they give medicine." – a man currently using contraceptives from Herat province IDI536

"Yes we are satisfied; our doctor is a good doctor. If we want medicine from the volunteers, they give us. If we want their telephone number they are willing to give it easily. They give us counsel and listen to our problems; they respect us." – a woman not currently using contraceptives from Herat province IDI526

"Yes we are satisfied; they take care of clients in a good way. They are not angry and violent; they show kindness to clients." – a woman currently using contraceptives from Herat province IDI515

"When we went to the health facility, it was crowded with many patients. Sometimes the workers get angry because of the crowding and their behavior is good. The doctor told us: 'consider spacing in births, you are coming here very frequently. The doctor was angry; she was not in good mood because of the large number of patients. She said: I am feeling tired, leave me alone for a while.'" – a woman not currently using contraceptives from Kunar province IDI123

"It is very easy to get birth spacing methods in the health facility. A woman can go by herself to the facility; she only needs to go with the packet of the finished pills, and get her card at the facility. The midwife receives the card and the finished packet of pills to register the new dose given and confirm that it is the right one." – a man currently using contraceptives from Kunar province IDI131

"When we got the IUD inserted at the [public] health facility, it was not free. I don't remember the exact amount we paid; I think it was 50 AFG. Usually the methods like tablets and injections are not free either; we must pay for them." – a man currently using contraceptives from Herat province IDI532

"When we go and asked doctor for BP check, they say we don't have. Yes they don't do it. If we bribe them, they do it, the hospital is like this." – a woman currently using contraceptives from Samangan province IDI412

3.1.7 The unique impact of social networking

Many women and men respondents acknowledge that they belong to social networks in which they discuss issues related to birth spacing and contraceptive use. They indicate moving together to seek health services (including birth spacing services), and taking into consideration the views and experiences of such friends and neighbors in decisions and practices related to family planning.

"Most of my married friends use methods, and all of them are happy from usage. We encourage each other and go to health facility together." – a man currently using contraceptives from Khost province IDI932

"I get information about birth spacing from my friends and acquaintances. I heard from them that a small family is equivalent to a happy family." – a man currently using contraceptives from Herat province IDI531

"Yes I talked with my friends and with my husband and they say I can have more children because I am strong and also I love children. My husband says that if Allah gives us two more boys it will be enough." – a woman not currently using contraceptives from Kunar province IDI126

"My uncle's wife and brother's wife use the methods. I didn't consult with relatives as everyone is busy with their work; nobody is talking about others children. If we get to know that a neighbor's wife also wants to go to hospital then we notify her to go together." – a woman currently using contraceptives from Bamyan province IDI811

Social networks are particularly important for women as opportunity for sharing experiences and relationship building. They are appreciated by many respondents as a trusted source of birth spacing information, especially as based on actual experiences of using birth spacing methods. However, there is little reflected in the discussions of respondents to show that women have appropriate social forums and adequate opportunity to express their birth spacing fears and experiences. This limits the opportunities to explore the implications of such experiences, and to use them as a basis for learning and achieving change. Although the FHA groups are noted as a potential mechanism for such engagement, there is limited evidence generated in this study that they have been adequately used to:

- A. Articulate and share the benefits and other positive experiences using birth spacing method; and use these as an opportunity to reinforce sustained use especially among the users experiencing problems and considering premature termination, and to encourage the couples that may be contemplating use

- B. Understand and address practical barriers to use of birth spacing methods; and constraints to sustained or full use in line with the desires and plans of each couple; and
- C. Articulate, understand and address problems attributed to use of specific birth spacing methods, including emerging side effects that may not have been recognized and documented before.

"Three of our family members are the users of family planning method: my mother in law, sister in law, and brother in law's wife. We often go together to the health facility to get the methods." – a woman currently using contraceptives from Herat province IDI512

"Some of my friends and neighbors persuaded me to use family planning methods." – a woman not currently using contraceptives from Badghis province IDI224

"My mother, sister and one of my neighbors persuaded me to use family planning methods so that I don't give birth to many children because they are enough." – a woman not currently using contraceptives from Samangan province IDI422

The study findings reflect that social networks beyond the family are even more important to men (compared to women) as a context for dialogue and decision making on child bearing and contraceptive use. Most male respondents pointed out very few or no other family members beyond their wives, with whom they discuss issues related to health and child bearing. Many among them indicate friends as the other category they discuss with and get information from. Similar to the situation with women, there was little in the discussions of male respondents to show that they have structured forums and/or other mechanisms to enable organized discussion of specific concerns and experiences related to child bearing, and to explore action options to address them.

These social networks are noted as an important source of information about birth spacing methods, and providing encouragement and social support to method use. This includes practical support in administration of methods such as injection.

"Our neighbor don't use the methods, we share information with them, to overcome the problems. As people of the same age, we talk with each other about such issues." – a man currently using contraceptives from Bamyan province IDI836

"The neighbors have persuaded me about the using of family planning method as it is good to help in birth spacing." – a woman not currently using contraceptives from Khost province IDI923

"I heard about the methods from women who use them. Some women having the injection come to me and ask me to inject it. Some women have problems with injection; I don't want to inject for them." – a woman not currently using contraceptives from Herat province IDI522

"My friends use this method [condoms] and I often consult with them. I don't need to go to the health facility." – a man currently using contraceptives from Kabul province IDI634

However, a number of respondents pointed out experiences of social relationships that are not supportive to the use of contraceptives, and the challenges they face in such interactions. Some noted that discussions about negative experiences of method use are a common basis for discouragement and decision not to use methods.

"I heard people use but I'm not using. Our neighbors who use are in troubles as they have bleeding problem. Then I thought to stop using this method which is causing bleeding. I chose to have many children instead of getting troubles." – a woman not currently using contraceptives from Jawazjan province IDI024

"Most of the relatives and friends are using the methods. Since the situation of Afghanistan is not good, people want fewer children. Sometimes we consult with each other but we don't go together to take methods because people think negatively about taking condoms." – a man currently using contraceptives from Herat province IDI533

"Some of my friends have 4 wives and have 30 children. I don't care about them, because it is their decision. If I tell some things to them, they will kill me." – a man currently using contraceptives from Khost province IDI931

"Some of my relatives and friends are literate, they don't see any problem in using family planning methods, but there are some of them who do not understand therefore, it is very difficult to persuade them." – a woman currently using contraceptives from Kabul province IDI615

3.2 Objective 2: factors at service delivery level

This section presents the analysis of findings addressing the second specific objective of the study, which is: to determine the factors at service delivery level (public & private) influencing modern contraceptive use by married couples. Provision of birth spacing services was discussed by three different categories of health care providers interviewed as Key Informants:

- ◆ Community-level volunteers; including FHA group members (providing birth spacing information) and CHWs (providing information and some of the birth spacing methods)
- ◆ Midwives at primary care level in public and private care settings, and
- ◆ Medicine dispensing staff in both public and private care settings.

Provision of other services relevant to planning for family wellbeing and development was not explicitly discussed in the study to the same depth. Aspects of population growth management were touched in Key Informant Interviews with Mullahs and Program Implementers in the provinces, and with policy level respondents at national level.

The results from the study discussions on birth spacing service provision are presented in this section under five subsections:

1. Provision of information and counseling on birth spacing and family planning
2. Provision of integrated birth spacing services at household and community levels
3. Provision of integrated birth spacing services in primary health care facilities
4. The unique role of private pharmacies and other points of sale in birth spacing service provision
5. Population and development planning and management

In general, there are three broad approaches to provision of birth spacing services in the country:

- A. Home and community-based information giving, counselling and methods provision by Community Health Workers (CHW), complemented by education, encouragement and referral by members of Family Health Action (FHA) Groups.
- B. Information, counseling and provision of methods as an integral element in primary health care services in government/public and private health care facilities and through private pharmacies and other sale points that stock birth spacing methods.
- C. Specialized counseling and methods provision at secondary level facilities.

Most of the discussions in this study were about (and with respondents at) the first two levels/approaches of service provision. Information provision and counseling on birth spacing appears to be largely diffuse and unstructured, focused mainly on a few short-term contraception methods as available in the health care system. Provision of methods is largely focused on introduction and distribution of three main short-term methods: Pills, Injections and Condoms. There is some provision of IUD in public and private health care facilities at primary level, but this is not yet developed and sustained at full scale. Provision of tubal ligation and vasectomy services was indicated as available at hospitals but was not extensively discussed in this study. It was also acknowledged that implant services have been introduced in some provinces over the last few years.

3.2.1 Provision of information and counselling on birth spacing and family planning

The provision of information and counselling, and development of critical life skills are key requirements for pro-active, effective and sustainable planning for family well-being and development, and for the specific considerations related to birth spacing. The discussions by respondents reflect limited opportunities and experiences for structured preparation process for children, adolescents and youth before they are married; to participate in (and eventually lead in future) planning for birth spacing and family development. This was only evident as:

- A. Informal and often unintended observation and discussion (e.g., through personal inquiry, warning and reprimand by parents, etc.) at family level;

- B. Occasional inclusion in community-level and school-based guidance and education sessions on these issues; and
- C. Incidental exposure through media (e.g., television, radio and internet), and to a less extent through printed materials.

Information provision and counseling to introduce methods is evident in the country, largely focused on married women with children; and to a less extent on older women with a critical social support role to the index mothers (e.g., between mothers in law and their daughters in law). The critical role of husbands in birth spacing decision making is well recognized, but there is limited provision of information and counseling to meet the unique needs of men. At community level, the institution of FHA groups is exclusively for women members and does not directly reach the men. On the other hand, the training and deployment of CHWs provides for a male and female CHW in each village, and thus provides good opportunity to reach the men.

The current design of family planning service provision especially at the public health facilities is not men (husbands) friendly. For example men are not allowed to visit midwives at the female section and there is no private room to talk to husband. The male health workers that provide services to the men at health facilities often lack the specific knowledge and skill to provide family planning counseling and are not deployed to provide family planning services.

Other elements limiting men access to counseling is cultural and religious beliefs in the society; for example in most of the cases husbands are not willing to join the counseling sessions together with their wives. Similarly, some of female providers are not willing to provide counseling to male clients due to the cultural and traditional limits to such interactions.

"Birth spacing services are offered in the women's section at the health facility; and men are not allowed there. In many cases, the man will tell his mother to take his wife to the clinic." – a midwife working in a public health facility from Badghis province KII232.

"Here no one gives permission to males to come into the discussions on birth spacing. We even don't want to give permission to a woman's husband to participate in the session. Their wives discuss the issue with us and then share it with their husbands at home." – a midwife working in a public health facility from Kunar province KII133.

"As this is Pashtoon society, men do not like to get services from a female doctor, and the female doctor also does not have permission to advise a man. That is why we give advice to the woman on individual basis." – a midwife working in a public health facility from Khost province KII932.

The CHWs as backbone of community based health care (CBHC) working in couples, play important role in providing counseling on birth spacing and family planning. The analyses of findings show that they do provide counseling on birth spacing to couples mostly on individual basis; the female CHW provide counseling to women whereas male CHW provides counseling to man. The findings show that it was not feasible for a female CHW to provide counseling to a couple together. Meanwhile, women may not seek counseling about family planning methods from male CHWs. Likewise the CHWs thought that most of couple feel shy and not comfortable to get counseling together.

"Female are guided on birth spacing by the female CHWs, while the males are counselled by the male CHWs. It is common that most of the families in a village are relatives or family friends; because of such close connections it is not easy to cross the restrictions and women interact with men, even in the health care process." – a female CHW from Badghis province KII212.

"If their husbands are present I am not able to provide education and counseling. This is because my family and daughter are living here. Our family does not allow other men from outside the family to come into our house, and we do not have any other specific place where we can sit with them." – a female CHW from Kandahar province KII716.

Information provision and counseling is virtually exclusively focused on enrolling married women to become users of available birth spacing methods. It mainly covers introducing the available methods and how to use them. There is recognition and utilization of the 'third-party agency role'; for example of husbands in decision making, accessing, and using birth spacing methods; mothers in law the decision making accessing and retention process; and of married women accessing and taking home methods for their husbands to use (e.g., condoms).

However, the study discussions reflect limited provision for complete and sustained communication (progressive and iterative decision making and methods use, follow up monitoring of use experience and action as necessary). There is no structured role of users as communicators/counselors; for example drawing from the global and in-country experiences in addiction recovery and rehabilitation, and in prevention of HIV where clients have a major role to play in peer service provision. There is still limited investment and progress in growing and spreading health knowledge and experience at family and community levels as a key component of health literacy.

The system-level dialogue on family planning reflected in the study discussions includes the three related concepts: family planning, birth spacing and contraceptive use, often used interchangeably depending upon the context of use. At program level and from a service delivery planning perspective, the term family planning is more commonly used, possibly in keeping with global perspectives. This is closely reflected in the study discussions with

policy and program level respondents, and is virtually absent in the dialogue of married women and men and other community-level respondents. The concept of family members planning together for specific areas of family needs and family development as described in section 3.1.3 is not explicitly described as 'family planning' in any of the discussions of respondents.

The use of the terms birth spacing and birth spacing methods is dominant in the study engagement with community-level respondents; often reflecting three distinct meanings:

- ◆ Birth spacing as a natural phenomenon experienced by families; seen as determined by Allah and not dependent on or a specific responsibility of the parents (wife and/or husband)
- ◆ Birth spacing methods as approaches under the full control of the parents, which are used to influence the interval between successive births; and especially linked to the duration of breastfeeding. These are often largely restricted to what was described as natural methods of birth spacing; characterized by: a) not needing the use of manufactured products that are not natural to the human body; and b) dependent upon the intervention and service of a third party – health providers and a health system that makes the methods available
- ◆ Birth spacing methods as manufactured products that are procured by parents, usually from the public health system at community or facility level, or from the private sector health facilities and sale points for health products, and used by the couple to prevent the occurrence of pregnancy and subsequent childbirth.

The study results show that it is not always clear to all parties which one of these three meanings is intended in the use of the term; which may result in misunderstanding and misinterpretation.

The explicit use of the term contraceptives is less frequent compared to the other two, and largely restricted to the discussions of some health providers and in the language used to describe the study. The multiple meanings in the use of the terms birth spacing and birth spacing methods, and the interchangeable use of the three terms: family planning, birth spacing/methods and contraceptive use may all contribute to some level of confusion and mis-representation. However, all three terms may have a legitimate and complementary role in describing the complex and multi-faceted process of child bearing and its management.

3.2.2 Provision of integrated birth spacing services at community and households level

Provision of birth spacing information and services at community and household level appears to be well developed in most of the provinces, through the work of CHWs and FHA groups; closely linked to other health and hygiene interventions.

The study findings indicate that CHWs educate the communities and couples on the birth spacing methods through utilizing set of IEC materials provided to them. Similarly, study findings highlight the active role of FHAG in improving awareness about birth spacing methods.

"Yes, we use the materials to educate people on all the methods that are available here. You can see all of them are shown in the pictures." – a female CHW from Jawzjan province KII014.

"We go to their house and tell them about their health, cleanliness, and about their child's health care so that they do not face malnutrition. We also talk to them about family planning methods." – a member of FHAG from Herat province FGD541.

The CHWs provide the birth spacing methods as part of the integrated service or intervention package. They provide birth spacing methods including pills, condoms and injections. The study highlighted limited skills for administration of injectable contraceptives among some CHWs. This is mainly attributed to limited or no training received on this skill, and the little or no practical training received for guided and supervised administration of the injections to build experience, expertise and confidence.

"We inject the women who are using injection method. We do this after each three months, which is the working period for every injection." – a female CHW from Herat province KII513.

"I cannot give the injection correctly I do not have enough skill in implementing it." – a female CHW from Khost province KII914.

"Most of the CHWs do not have enough skills in implementing Depo-injection. This is true, they do not have enough knowledge/training; they are not professional health workers." – a male CHW from Kunar province KII112.

"Through conducting training sessions about administration of the injections and practical work may help them to improve." – a female CHW from Badghis KII212.

The study findings reflect limited attention in the services of CHWs and FHA group members to the broader aspects of planning for family well-being and development. Other elements of integration that are not fully developed include:

- A. On-going cross-generational communication and dialogue on child bearing and birth spacing at all stages of the lifecycle, beyond the current focus on married women and at time on their husbands as well;
- B. Support for self-driven use of user-controlled birth spacing methods (e.g., the natural methods);
- C. Enhancing the empowerment of couples in managing the use of provider-supported and user-led methods such as condoms and pills, and increasing the user-led administration of injectable contraceptives;
- D. Promoting the use of long acting methods of contraception that are largely provider-controlled; and supporting access to such methods through outreach and campaign-based mobilization by CHWs.

In addition, there is limited evidence of structured integration between the community-based birth spacing services and other development services such as education, communication, finance support, etc. It is notable that Mullahs and other categories respondents highlighted key Islamic tenets on family-based planning as a critical ingredient in overall development direction of society.

"It is good if women who give birth without spacing to consider birth spacing; it is good for both the health of children and mothers. Their economic situation will get better 100%, if they have more children they will not be able to maintain services for them such as food and clothing. That's why fewer children are good for the economy of a family." – a Mullah from Jawazjan province IDI062

"We emphasize on well behaved and educated children; that is why family planning is so important. The parents should think about the needs of the children; their education, clothes, and their future; based on the economic quality of their family. In schools, mosques and in some ceremonies such as religious and other ceremonies, we discuss and talk with people on the quality of children." – a Mullah from Badakhshan province IDI363

"If this war ends and security returns, God's will is that in Afghanistan everyone has two or three families. If one or two children are born in every family, the population will reach 45 Million or possibly will reach 50 million." – a Mullah from Herat province IDI561

The unique role of family members, experienced users, and FHA members in community and household level provision of birth spacing services is evident and evolving in the following areas of service:

- A. Communication that prepares potential users of birth spacing methods to consider their situation and the value that birth spacing adds; and to introduce available birth spacing methods
- B. Supporting the process of dialogue and decision making for use of birth spacing methods,
- C. Supporting method change considerations as the family progresses with their childbearing goals at different stages of the family life cycle

However, elements of service delivery at community level that are still underdeveloped include: a) meeting the unique needs of men as family planning users; b) support in understanding, anticipating and managing negative experiences/problems truly associated with birth spacing methods; and c) support in understanding and addressing health problems that may occur alongside use of birth spacing methods but are not attributable to their use.

3.2.3 Provision of integrated birth spacing services in primary health care facilities

In the public health facilities, the delivery of birth spacing services is integrated into the other primary health care services. It is integrated in the three main phases of the health care process as delivered at primary health facilities:

1. Daily group-based health education sessions – often with a schedule for systematic coverage of priority issues, including provision for adequate inclusion of birth spacing (e.g., one day per week for focus on this issue)
2. Individual-based clinical care – using a ‘consultation’ approach, with some evidence of evolving adaptation to the ‘counseling’ mode of interaction. This includes provision for ‘third-party’ participation, for example in consultation for children, and for adults not able to communicate with provider because of language difference, being too sick, disability, etc. There is indication of efforts to adapt this ‘third-party’ system to meet the unique needs in birth spacing service provision, such as inclusion of husband and/or mother in law in the consultation and counseling processes. However, the dominant approach to achieve this is still largely external, based on serial dialogue and iterative consultation as described in Section 3.1.5.

3. Treatment administration – usually done by the ‘consulted staff’ and/or another third party. In all the public health facilities covered by the study process, provision of birth spacing supplies is done as an integral element in other maternal, newborn and child health service provision. This is mainly delivered by midwives as the sole service provider for all services needed by each client. However, there are experiences discussed of involvement of other staff in the service provision chain for birth spacing. Such staff are most often not midwives and not females; and may thus lack the necessary skills and social acceptability to provide birth spacing services especially to the female clients that dominate service uptake.

The study indicated that most of the time, the birth spacing methods are stored in the stock of public facilities and meanwhile a small quantity is kept with midwives for daily distribution. It was noted that women preferred to receive the methods directly from midwives rather than the pharmacists as women may feel uncomfortable to receive their methods from male pharmacist.

“It is not easy, to get it from the midwife, as some of the women feel shy when they go to the doctor or to the pharmacy, so we have it for those women to come to us and get the method from us.” – a midwife working in a public health facility from Badakhshan province KII332.

“The methods are stored in pharmacy then we request according to our need they give us. We also have them in stock in enough quantity. We give methods to women and register them and provide them card.” – a midwife working in a public health facility from Jawzjan province KII032.

The study indicated that midwives at the public health facilities were mostly providing pills, injection, tablets and IUDs. The findings indicated that midwives provided consultation on long term methods, but most of their clients were not interested to receive the long term methods. The midwives perceived that their clients were not interested because: some women desired to get pregnant again after two to three years; some women would not use due to low level of awareness and knowledge on long term methods; some of the clients not using it as they would do heavy work; husband and family did not allow them; some of them believed that using IUD would make them infertile forever. Some women believed that their prayers and funeral prayer would not be acceptable to God. Some women perceived they might get cancer. Some women did not use because of perceived and actual side effects; some feared that they would not be able to remove IUD while some feared that it may rupture the uterus and enter to intestine and stomach.

"Yes, people use IUD but very less. They think it will cause negative effects, a woman will not be able to give birth forever, it will cause infection or cause abscess. People use IUD method but not much." – a midwife working in a public health facility from Badakhshan province KII335.

"Married couples are afraid of using IUD because they have the idea that it may be displaced during daily activities, or they won't be pregnant again in their whole life." – a midwife working in a public health facility from Herat province KII531.

"Our clients don't use it, and when we ask about the reason they say that they don't want to use it because they were doing heavy work. They said that their husbands don't want using the method. That is why more clients use injection or tablets because it is easy to use and their husbands accept these methods." – a midwife working in a public health facility from Badghis province KII331.

The discussions highlighted gaps in staff skills and experience in delivering some of the elements of birth spacing services, especially with regard to provision of long term methods and provision of comprehensive counseling. It was noted that a number of midwives are not able to confidently and accurately insert IUD.

"First, I did not participate in any kind of training and second I do not have enough experience in the installing IUD. All the misconceptions that exist at the village, people are not ready to use this device. That is the reason the client of this device is getting decreased." – a midwife working in a public health facility from Herat province KII533.

"Some midwives do not have the skill to implement IUD. It is possible that some of the midwives cannot implement the IUD properly, or it is replaced which causes some disadvantages." – a midwife working in a public health facility from Jawzjan province KII035

Training in implant provision has been introduced in some hospitals and health facilities, but is not yet scaled up to the other levels. The study noted that most of midwives in public health facilities had not participated in any training on implant and they are not able to implement the implant method.

"I didn't receive the training and don't know how to implement." – a midwife working in a public health facility from Kunar province KII132.

"I cannot insert the implant because I don't have the skills. We have not received any training on this new method, and it was not covered when we were in school." – a midwife working in a public health facility from Jawzjan province KII035.

Supply chain management gaps were noted with respect to communication materials and specific methods with high consumption rates (e.g., condoms and pills). The findings highlighted the some level of methods shortage at the service delivery points of public health facilities during the last year prior to the study implementation.

"Yes, we faced shortage of pills for four months." – a midwife working in a public health facility from Jawzjan province KII033.

"Yeah, we faced shortage of injection method (Depo provera)." – a midwife working in a public health facility from Kunar province KII135.

"Yes we face shortage of method and also we don't have POP tablet and injection now. , Sometimes during one quarter we don't have methods for 10 and 15 day." – a midwife working in a public health facility from Kandahar province KII732.

Appropriateness of health service providers' behaviors with clients was a concern at some of the service delivery sites. The study findings noted having inappropriate behavior by some of the midwives, which may cause dissatisfaction of clients.

"Yes there are some midwives that behave rudely with the clients and it belongs to their own morality or maybe because of too many patients or work's load and they are not able to handle their children noise in a better way therefore, they lose their temperament sometimes. – a midwife working in a public health facility from Badghis province KII233.

"I do not think so that we have bad behavior. However, patients have high expectation. Some time, the patient come in unofficial time, like in the time of praying, in the time of lunch, and this cause inconvenience to the health worker. As a result patients get in trouble. – a midwife working in a public health facility from Herat province KII534.

Adequacy and appropriateness of communication, education and counseling materials was a concern at a number of service sites. This was particularly with respect to the mandate, responsibility and support systems needed for reproduction, adaptation and sharing of IEC materials for both public and private health facilities.

"Yes, we have flip charts and posters. We are showing other methods to our clients too and based on the methods we provide consultation of FP. We do not have the Contraceptive Medical Eligibility Wheel Chart and I also haven't information about it." – a midwife working in a private clinic from Jawzjan province KII045.

"We don't have counseling cards with us but we have register book, flip chart, family planning posters and also we don't have contraceptive medical eligibility as we just provide condom, tablet, injection, and IUD." – a midwife working in a public health facility from Kunar province KII132.

Other concerns noted with respect to service delivery are related to inadequate support systems for birth spacing service delivery such as:

- A. Provision for men who come to the health facility to receive the full scope of family planning services, since most male staff are not oriented and deployed to provide such services, and socio-cultural restrictions limit contact with the female health workers
- B. Physical space for basic clinical services, to enable delivery of 'group-based' consultation and counseling in privacy (e.g., for a woman and her mother in law, or with her husband)
- C. Specialized space and equipment for provision of long acting reversible contraception and permanent methods as demanded
- D. Balance between staff categories and numbers to manage delivery of integrated services to the large number of service users (e.g., managing the crowding, reducing waiting times, and ensuring quality service for all).

It was noted that options and opportunities for targeted/customized services have not been fully harnessed. These include post-partum birth spacing services as an integral element in post-natal and child health clinics; and periods of targeted services such as intensified service delivery campaigns and social marketing approaches.

In private health facilities most of the time, the birth spacing methods are stored in the stock and meanwhile a small quantity is kept with midwives for daily distribution. It was noted that women preferred to receive the methods directly from midwives rather than the pharmacists as women may feel uncomfortable to receive their methods from male pharmacist.

"It is not easy, but is easy to get it from the midwife, as some of the women feel shy when they go to the doctor or to the pharmacy, so we have it for those women to come to us and get the method from us." – a midwife working in a public health facility from Badakhshan province KII332.

"The methods are stored in pharmacy then we request according to our need they give us, we also have but in stock there is enough. We give methods for women we register them and provide them card." – a midwife working in a public health facility from Jawzjan province KII032.

The services in private facilities reflect a similar methods range of birth spacing methods and provision approaches as in the public facilities. They are largely dominated by pills, condoms, injection and IUD as the available methods. There is a similar pattern of provider and user preferences across the available methods. The notable differences in the private facilities are:

- A. No experiences of method stock out;
- B. Less attention to group-based education and family-focused counseling and dialogue
- C. No referral connection to community-level service provision and promotion (CHWs, FHA, etc.); and
- D. Less opportunity for in-service training (as planned and supported by government); similar access to BS-related IEC materials

The study noted that in private health facilities providers were providing pills, injection, tablets, IUDs and some of them provided implant. The findings highlighted that the private facilities had very few or no experiences of method shortage.

"They are always available; we did not face shortage of the method." – a midwife working in a private clinic from Badakhshan province KII341.

"You better know we are from private sector; they are always available here." – a midwife working in a private clinic from Herat province KII542.

In private health facilities, provision of counseling and involving men in the process of counseling seems to be hindered by social norms in the country. According to midwives the husbands do not come with their wives because they consider that to be the concern for women and are thus not interested to come with them. Some of the husbands feel shy and not feeling comfortable to come with their wives for counseling. Similarly, some of the female staff in private settings report not being able to provide counseling to men client due to cultural restrictions.

"We are trying to provide both types of counseling but when we ask about their husbands they say that, they are not willing to visit a female doctor." – a midwife working in a private clinic from Badakhshan KII345.

"We just consult with women because males are in big number. We can't talk with all the men and also we don't have permission of family whenever patients need information, we talk with husband from back of the door." – a midwife working in a private clinic from Badghis province KII241.

In the private health facilities the findings note some gaps in staff skills and experience in delivering some of the elements of birth spacing services, especially with regard to provision of long term methods and provision of comprehensive counseling. It is noted that a number of private providers were not able to confidently and accurately insert IUD. Likewise, most of them mention that they are not able to implement the implant method. Most of the midwives mentioned lack of training, lack of information and skill as one of the main barrier for not being able to implement this method.

"Yes there are some who cannot implement IUD." – a midwife working in a private clinic from Jawzjan province KII342.

"No, I cannot because I did not participate in training of implant method." – a midwife working in a private clinic from Badakhshan province KII343.

Provision of birth spacing services in some of private health facilities visited in the study process appears to reach a self-selected set of clients, mainly based on their ability to pay for the services. Some of them also have specific interest to seek the services of known individual providers, usually based on previous service experience with them, often through public facilities. The private services are prized for having confidential, personalized and quick services, as illustrated in these quotes. Furthermore, the clients of private providers seemed to be satisfied with the behavior of the providers.

"Giving good advice to the client and having good behavior to the client. These are good ways that make people to come back again." – a midwife working in a private clinic from Herat province KII544.

"In the medical field, behavior is very important. With good behavior, women and patients can be satisfied. When doctors and midwives don't behave well, patients will not be satisfied. Maybe it happens due to large number of patients. Or it is possible that a woman who wants to take the birth spacing methods doesn't have enough money." – a midwife working in a private clinic from Herat province KII545.

Service cost concerns are seen as an important deterrent to 'specific method uptake; especially the long term methods such as IUD and implant. Such concerns also limit continued attendance for resupply of short-term methods, follow up care, method change, etc.

"To start from short term method, it is condom, injection, tablet and IUD methods which we have available in our stock. If our client would like to use we can make ready and apply the implant method as well. The implant method is very expensive in the market.." – a midwife working in a private clinic from Jawzjan province KII042.

"One of the barriers is lack of the methods: when there is shortage of the methods, the level of users will come down. High price of the methods: most people are poor and they cannot buy the methods." – a pharmacist working in private pharmacy from Herat province KII551.

3.2.4 The unique role of private pharmacies in provision of birth spacing methods

The important role of private pharmacies and other points of sale for birth spacing methods is well recognized and discussed by both providers and clients participating as study respondents. They are noted as an easily accessible source of birth spacing methods, especially in the urban settings. They are often located very near to high concentrations of potential clients, for example close to where they live or where they often go for other transactions such as markets. They are also seen as more socially accessible compared to health facilities, because of their long and flexible hours of operation, and because they allow some level of anonymous access. For example, they do not ask for or record many details about clients, they provide methods as prescribed by doctors without asking a lot, some provide advice on methods and their use, while others agree to give methods as demanded by clients without any hesitation.

"While coming to our pharmacy their faces are hidden and we don't know who they are. I know some of them who are coming regularly, but we do not have records of them. When we were distributing injections in the past, we had registration book; now they come without their card that's why we don't know them." - a private pharmacy worker from Badghis province KII255

"As most of the women come to us in Borqa (Hijab), we do not know exactly who they were. Either they had come for the first time or it is their second or third time." – a private pharmacy worker from Kabul province KII651

"We can't distinguish between people that he is the one who came to our pharmacy or not, because it is private pharmacy. People take the method from wherever they can access it, it is not like they have a contract with us to keep getting the method here." – a private pharmacy worker from Kunar province KII152

Some respondents note that these private sector sources of methods are a necessary complement to the services at public and private health facilities. They are recognized as the primary means to get methods prescribed in private clinics. They also are the main source of methods that may be out of stock at public health facilities. Some of the study respondents based at these private method sources indicate that they stock methods based on what clients are unlikely to get from the nearby health facilities. This situation is particularly reported by most of the private pharmacy respondents in Bamyan province.

"As the clinic is located in our neighborhood, people get methods such as pills and injections from the clinic. We only have and sell condoms to our male clients." – a private pharmacy worker from Kunar province KII155

"We did not face shortage of methods here. They get from the hospital, when it is finished, they come to us." – a private pharmacy worker from Badakhshan province KII351

"I don't have birth spacing methods here, because they are available in the clinic or hospital. Since the hospital is near and has enough methods so people go there to get the methods. If I procure into my pharmacy no one will come here to purchase." – a private pharmacy worker from Bamyan province KII851

Many of the private pharmacies stock the same range of birth spacing methods as available at public health facilities; mainly pills, condoms and injections; in a wide variety of brands and from many production sources. A few respondents indicate stocking of IUD and implants, usually in small numbers. The stock levels reported in visited sites are

generally low, and this is largely attributed to the fact that most of them are operated by individuals that have limited capital to use for the business, for example to procure larger stock. Others indicate that it is a deliberate strategy to avoid expiry of methods that are not on high demand, which means high losses for the business. The other factors discussed that influence stock levels and stock out experiences include: availability of methods at the wholesalers, the frequency and regularity of method distribution by some manufacturers, and the level of demand for specific methods.

"For the period of three months Khoshi tablets were not available in our stock." – a private pharmacy worker from Badghis province KII251.

"It takes one or two weeks till we go to bazaar to procure more methods. Now we don't have Khoshi injections and Nova tablets." – a private pharmacy worker from Kandahar province KII751

"No, we never faced the problem of stock out. We bring more supply before the methods get finished." – a private pharmacy worker from Herat province KII553.

"In this year we used only two IUDs; two of them expired." – a private pharmacy worker from Kunar province KII125

The private method sources visited in the study exhibit a wide range of price levels for the different methods in stock, largely based on the specific brands and the amounts as packaged for sale. Many of them indicate flexibility to re-package methods and to negotiate prices in line with what clients can afford. There is wide recognition of the fact that the cost of methods is an important constraint for many clients. The approaches discussed as often used to counter this include: stocking of low cost brands of the popular methods, price reductions and packaging amounts in line with what each client can afford, and referring of some clients to health facilities where they can get free methods.

"We have different pills and the usual price is 90 or 100 AFN. Some of our clients cannot afford and we give them at 80 AFN." – a private pharmacy worker from Jawazjan province KII051

"Some of the clients are very poor and they cannot buy pills for the full month. We give them for one week and they return for more when they get the money." – a private pharmacy worker from Kandahar province KII751

"We have pills at different prices, the maximum price is 100AFN. We are selling it according to the clients, whoever has low economy level and can't buy we help them." – a private pharmacy worker from Jawazjan province KII052

"Some women come regularly and they get her methods but, some women do not come regularly to take their methods and also some time we refer them to clinic; because the methods are free in clinic." – a private pharmacy worker from Badghis province KII253

3.2.5 Systems support to family planning service provision

The provision of birth spacing services is acknowledged as an important element in the realization of the population and development planning goals in Afghanistan. It is an articulated key focus area in the 2016-2020 national health strategy, as an important component in improving access and utilization of reproductive, maternal, neonatal, child, and adolescent health services. The 2017-2021 national RMNCAH strategy has birth spacing/family planning as the sixth among the nine core strategic components. The family planning component is to be delivered through the following strategic approaches:

- ◆ Promoting family planning through advocacy and policy dialogue
- ◆ Strengthen the capacity of health service providers to provide a full range of family planning methods
- ◆ Improve provision of BS/FP services at all levels
- ◆ Strengthen Community-Based BS/FP approaches
- ◆ Increase information, education and communication (IEC) and behavior change communication (BCC) for wider use of BS/FP
- ◆ Integration of BS/FP services into all levels of the private sector

Achievement of these intentions depends on prioritization of birth spacing service provision in the health sector, and necessary attention to birth spacing and its impacts in the other sectors. Study respondents noted that this is currently constrained by absence of a comprehensive and costed implementation plan for the RMNCAH strategy.

3.3 Objective 3: Socio-cultural, religious and policy factors

3.3.1 Socio-cultural factors influencing use of modern contraceptives

a) Early and arranged marriages as a continuation of the child bearing and family expansion aspirations of grand parents

Many of the women respondents and some among the men respondents indicate that they got married as adolescents. They often have limited learned or experiential knowledge and social skill to make independent child bearing and child care decisions. The predominant social norm is for such couples to make child bearing, birth spacing and contraceptive use decisions based on the guidance and expectations of their parents. The agency role of the couple's parents in such decisions is also widely accepted and expected. It is notable that some of the grandparents are still in reproductive age but may be constrained by social norms from continuing child bearing alongside their children. Those grandparents that are older may still have unmet childbearing aspirations (e.g., few children, few sons, etc.) that they desire to attain through their children and grandchildren.

"I did not know about birth spacing methods before marriage as I was too young when I got married." – a woman currently using contraceptives from Badghis province IDI212

"The health workers should educate the people even more about family planning. As we see now, many girls get married when they are still very young, some of them even die while giving birth because they cannot deliver." – a man not currently using contraceptives from Kunar province IDI144

"My daughter in law has not consulted me yet about child bearing. She is still too young to have children. But in future I want her to have 3 or 4 children." – a mother in law from Khost province IDI952

"I also talk to my daughter in law about number of children because I have one child and I want my daughter in law to have 4 or 5 children." – a mother in law from Jawazjan province IDI051

"Some people say that children are like fruits from the heaven, the more you eat the more you want. Other people say that 3-4 children are enough and they do not want more; the opinions differ a lot. I think 13 children are good. I have 2 sons and 6 daughters. One should have 4-5 sons and 2-4 daughters." – a mother in law from Kabul province IDI653

Many among the women and men respondents acknowledge dialogue with their parents on child bearing, birth spacing and use of contraceptives. Similarly, most of the respondent mothers in law acknowledge their social mandate and practical experience of influencing their children's child bearing. In a few instances, it is acknowledged that the ultimate decision is a choice of the couple concerned.

"At first I was so eager to have many children and now Allah has given us these four children. I tell my son that these are enough and also we should educate them well." – a mother in law from Kabul province FGD632

"We discuss about this issue [number of children to have]. My daughter in-law is a very good woman and I tell her let your children grow up and understand; and then give birth to another child. That way you and your children will not be in torment. My daughter in-law is not bad; it is her mother who is bad. She tells her that your mother in-law is envious; that is why she does not let you have more children. But I don't mind how many the children are; I just tell her let your children grow first then birth another one. Also my son's income is not good we face economically problem sometimes that's why I tell her that." – a mother in law from Jawazjan province IDI053

"I got another girl to marry my son and bring more and more children." – a mother in law from Kabul province FGD631

"We have not discussed about such issues. My children have to make their choices about the number of children they want to have." – a mother in law from Kunar province FGD132

"I didn't tell them about the number of children to have. It is up to them to have as many children as they like. If they can meet their needs and can keep them clean, they can give birth to more." – a mother in law from Khost province FGD932

b) Extended family living arrangements

Most respondents in the rural setting and some in the urban setting live together as an extended family unit of multiple generations. These extended families are usually led by elders (parents or grandparents to the couple), and often include several brothers and their families. This context allows for persistent social pressure and reinforcement for adherence to the views of the elders. It also provides opportunity for exchange of experiences across the siblings' families and a common approach to birth spacing and contraceptive use decisions. In some cases, this includes competition among such families on issues such as number of children, balance between boys and girls, etc. The other key element in such contexts is the perceived and actual availability of help in child care, a common motivation to have more children.

"If my daughter in law talks with me I will tell her to get more children because this is from Allah. I do not give permission to my daughter in law to use birth spacing methods; she should have 8 children." – a mother in law from Badakhshan province FGD332

"If someone has many children and many grandchildren, no one gives him/her a house for rent because they are so many people and they might break the windows, doors and damage the house. The owner of the house will charge them for all damages; and if they are poor they will have a big problem. Therefore fewer children are good to have clean house, clean environment." – a mother in law from Kabul province FGD632

"A daughter in law should accept the views of the family head. She should use the family planning methods because four children are enough." – a mother in law from Badakhshan province FGD331

"We have talked about child bearing and birth spacing, but my mother does not permit my daughter in law to stop more pregnancy." – a mother in law from Badghis province FGD231

c) Social norms and perceptions of child bearing and family size

There are some strongly held social norms about child bearing and family size that influence the child bearing and contraceptive use decisions of couples. To begin with, the ability to bear children or to stay without any children is perceived as a reflection of the blessing of Allah or luck in one's life. The social perceptions and interpretations linked to having what is considered to be a small number of children include:

- ◆ Inability of the parents (usually the woman) to bear more children, and often a justification for the man to marry more women
- ◆ A reasonable choice for families with limited economic capacity and thus unable to provide for a larger number of children
- ◆ A wise choice of parents that is based on balancing between the health and welfare of the mother, and the development goals they have for their children (e.g., teaching them manners and morals, ensuring their education, etc.).

"Some people say couples with few children have no ability to feed a big family. More children are good; if they are five or six it is good. One will be a farmer, one will be a shopkeeper; but two or three children are too few." – a mother in law from Badakhshan province FGD332

"If a person has no children or has one or two children, people say he has a few children and if he has more than two or three children then they don't talk too much. If a person has few children and gets old, he spends the rest of life like a single person and also makes his mother disappointed." – a man currently using contraceptives from Kunar province IDI133

"People tell them it is shameful that you don't have children, it is sin that you don't have child. One of my brothers does not have child, all people tell them it is shameful for you that you cannot pregnant your wife. (You are not able to have children)." – a woman not currently using contraceptives from Kabul province FGD622

In contrast, the social interpretations and norms attached to a large family size include: an indication of the blessing of Allah with children and the ability to provide for them; or a reflection of family wealth status based on their hard work. In situations where a couple with many children does not appear to be providing adequately for their needs and upbringing, this is often interpreted as a bad choice or an unwise decision of the couple.

"It depends upon the blessings of Allah that how many children He will bless. Allah blesses some of them with more, some with less, while some of them with none." – a mother in law from Badakhshan province IDI353

"If a couple has no child, some people call them losers." – a man currently using contraceptives from Bamyan province IDI831

"In the villages there are different opinions. Some illiterate people just want have maximum number of children, they do not take care of their children future and they do not know about the future of their children. There are some open-minded people who think about the future of their children and they do not want to have more children." – a mother in law from Kabul province IDI652

"Their children are their supporter and they are happy with supporters. People don't say that they are un-lucky or anything else; they just focus on the point of supporters. They are happy whatever their supporters increase and become powerful." – a man not currently using contraceptives from Kunar province IDI144

d) Transition in norms about family size and use of birth spacing methods

Many respondents acknowledge a trend of change in social perceptions and norms about family size and use of birth spacing methods, from preference of large family size based on uncontrolled child bearing to one's natural potential, to having fewer children through use of birth spacing methods. This is mainly attributed to:

- ◆ Increased availability of health services that has resulted in greater awareness about and utilization of birth spacing methods
- ◆ Education and other forms of exposure (e.g., moving from rural to urban areas, migration to other countries, etc.)
- ◆ Age-based difference in perceptions of young adults compare to the older generation (parents, grandparents, etc.).

"In the past I was at home; I had no job. I was giving birth frequently, I did not use birth spacing methods and the methods were not available. Now we have a clinic and I know about the birth spacing methods, and my last child is 3 years old." – a woman not currently using contraceptives from Jawazjan province IDI022

"The people who are educated agree to use these methods, and those people who are less educated or have no education are against of using these methods, but in general everyone has their own opinion." – a man not currently using contraceptives from Herat province IDI541

"If some people are knowledgeable and educated, then they say that it is good to use birth spacing methods. They say that their children will grow up well and can get education. But some people like us living in remote areas the perceptions are different. They say that those using birth spacing methods cannot feed, clothe and educate their children, and no one likes to associate with us." – a man currently using contraceptives from Khost province IDI931

"In the past people said that it is sin and therefore you should have many children. Now it doesn't have any problem all people know and are informed.." – a man currently using contraceptives from Samangan province IDI435

"In the past people thought negatively about that, but now people know better. The population is now more and income is less; two, three, or five children are enough. The economic situation of people is not good; people cannot provide for thier children everything they need." – a man not currently using contraceptives from Badakhshan province IDI343

"We don't know that. We should ask someone regarding that. One day I was in a funeral ceremony. I showed the tablets to one of my friends and have asked him regarding use of tablets, he has answered me: "no problem you can use that" – a man not currently using contraceptives from Khost province IDI943

e) Recognition and respect of the mandate of couples to make decisions on child bearing and contraceptive use

In a few instances, respondents reflect a social norm of allowing couples their due space to make decisions about child bearing and contraceptive use. However, many emphasize the critical balance between the right of couple to make such decisions, and their responsibility to ensure that they meet the child care and nurture responsibilities for all the children they bear. Some also noted the need for such couples to be clear about their child bearing goals; and to have the resolve and mettle to withstand the social pressures exerted by extended family members and other associates.

"In our village the people do not say anything about this because husband and wife are the decision makers about their children. If a couple has less children, people may say that this family is a lucky family because they can provide every thing to their children." – a woman currently using contraceptives from Bamyan province FGD812

"Everyone has his/her own choice and no one interferes in others' businesses. In current conditions if someone has more children, people say: "why they give birth to many children, how would they provide them clothing?" – a mother in law from Kabul province FGD632

"God gives children, so childbirth should not be prevented. Children are good and useful. Some say that children are not useful, therefore it is good to have fewer children. Others say that using methods is a guilty action and say that don't prevent giving birth. I respond to them that having more children will make you weak and will cause problems.." – a woman currently using contraceptives from Herat province IDI516

3.3.2 Religious factors influencing use of modern contraceptives

The dominant view among the male and female respondents is that Islam has restrictions against use of birth spacing methods, but also provides for exceptions when such methods are permitted. The reasons indicated for restriction of use of the methods include:

- A. It is seen as a form of opposition to (or disbelief in) God's will to give the set number of children to each couple, and the promise to provide food for them as given
- B. It is considered as a disservice to the prophet Mohammad (PBUH) and his expectation of a great number of followers on judgment day
- C. It is interpreted as murder of the unborn child
- D. The restriction especially applies to methods that were not in use during the time of the prophet (as evident in his writings)
- E. Not using the methods is regarded as a feature of the uniqueness of Islam in comparison to other religions
- F. The perception that experiences adverse effects by some of the people who use the methods is a reflection of the fact that using the methods is wrong
- G. Using the methods does not attract any reward in Islam

a) Islamic teaching about the family duty of childbearing and child instruction into the life and values of obedient Muslims

The dominant perception among respondents is that Islamic teaching about the duty and opportunity of all Muslim couples as granted by Allah is to bear children and raise them into obedient followers of the Prophet Muhammad (PBUH). This is seen by many as a direct and irrefutable contradiction to use of birth spacing methods; which action is interpreted by some as sinful and equivalent to the killing of unborn children. A lot of emphasis is placed on the number of children born and raised well in each family as a direct reflection of the success of the family in this religious duty.

"Birth spacing methods are not allowed in Islam, because Allah gives you and you have to accept. If we change the will of Allah, it is not allowed in Islam." – a man not currently using contraceptives from Jawazjan province IDI045

"Islam says you women should born children, as many as a woman can." – a woman currently using contraceptives from Khost province IDI915

"In Islamic opinion it is not allowed because Allah blessed us with children and we should accept this blessing." – a woman currently using contraceptives from Samangan province IDI414

"The people say it is a sin to use contraceptives. After giving birth to my last daughter, I took the decision to start using them but when my husband talked with Mawlawi (religious scholar) he was told that it is sin. My husband told me you are taking this medicine but the Mawlawi said that if you are a Muslim and you take the medicine you will be a murderer because it is forbidden in Islam. After that I decided to stop because I don't want to be murderer. Thanks to Allah that we are Muslims." – a woman not currently using contraceptives from Samangan province IDI421

"It is clear that it is sin to use contraceptives. It says that the children that Allah gives; he also gives their sustenance. If a person has the capacity, it does not matter how many children they have." – a woman not currently using contraceptives from Herat province IDI526

"The prophet Mohammad (PUBH) said we should have many children. According to Quran Sharif, Allah gives food to us in every place. So it is better the Muslim children should be more." – a man not currently using contraceptives from Badakhshan province IDI342

Some respondents emphasize the specific context in which this religious rule applies, such as the economic ability of the family to provide for the needs of all the children they bear. Others point to negative life consequences that may come to those who disobey and use contraceptives; including the view that some of the side effects of method use are a result of this disobedience. Some even point to the unique situation of war in the country as another underlying justification to have many children.

"From Islamic point of view, Muslims should have a lot of children only if they could afford (proper health and education)." – a man currently using contraceptives from Kabul province IDI631

"I am illiterate, but my husband says that anyone who takes pills to stop pregnancy she will go through monthly menstrual cycle. Each month the blood would equal to killing a human being. I am also afraid of God that how would I justify to Him. I have so many other sins. And I don't want to be a killer by using the method." – a woman not currently using contraceptives from Kabul province IDI624

"It is a sin, if the people prevent children birth, so the number of Muslims will decrease. I really get upset as it is sin. I am afraid of anything unfortunate will happen to us." – a woman currently using contraceptives from Kabul province IDI612

"In Islamic opinion it is not allowed because in Afghanistan here is war and we need \ youths." – a woman not currently using contraceptives from Kunar province IDI124

In contrast to this dominant view, there are perceptions expressed that highlight the value of birth spacing methods as a means and not a contradiction to achieve this duty, especially the aspect of enabling the family to raise the children well. Some respondents emphasize the agreement between the wife and husband or the need for the husband's permission to use the methods. Others highlight the fact that this interpretation is an element of transition in Islamic teaching, and also more common among Islamic Scholars in particular schools of thought and interpretation.

"In the view of some people it is not good. They say God will be angry. Others think that it is good, it enables parents to take care of their children." – a woman not currently using contraceptives from Herat province IDI524

"We asked from Mullah and mullah gave positive answer because the mother can take care properly of her children and it is allowed in Islam." – a man not currently using contraceptives from Jawazjan province IDI041

"In the past the prophet and his companions children were also many. They could not feed them because they were poor, so they were having space between the children." – a man not currently using contraceptives from Kandahar province IDI741

"It is allowed in Islam as Islam says, few children are better in order to provide them better education, health, and happy life." – a woman not currently using contraceptives from Khost province IDI925

"If a woman uses birth spacing methods without her husband's permission, then it is a sin." – a woman not currently using contraceptives from Badghis province IDI224

"I did not go to school. Using methods might be good or is allowed, as I have the permission of my husband, if there is no permission from husband, it might be forbidden." – a woman currently using contraceptives from Samangan province IDI416

"In past religious scholar used to say it is a sin but now I heard they say it is permitted to use such methods." – a woman currently using contraceptives from Kabul province IDI614

"Islam said that Allah gives children to the humans and we cannot create something. Before there was no method for preventing child bearing; these methods have just been discovered." – a woman not currently using contraceptives from Herat province IDI521

b) Conditional allowance of contraceptive use by Muslim families; and prohibition of specific methods of contraception

There is broad appreciation of the specific circumstances in which it is justifiable to use birth spacing methods within the provisions of Islamic teaching. Such circumstances include:

- ◆ Use to ensure and protect the health and wellbeing of the child – especially to meet the specific requirements for full breastfeeding in line with Islamic perspective

"It has been stated in Quran that a child should be breastfed up to 2 years therefore. It is allowed in Islam to use family planning methods to achieve this." – a man currently using contraceptives from Kandahar province IDI735

"In my view, and as taught by Imam Sahib, the breastfeeding must be for thirty months; while the Imam Shaafi says that breastfeeding should be for two years. The common teaching is that birth spacing should be up to thirty months or two and a-half years, while the child is still breastfeeding. Islam allows parents to use birth spacing methods to achieve this interval between deliveries." – a man currently using contraceptives from Kunar province IDI131

"In my opinion there is no prohibition in Islam regarding FP as in Holy Quran it is mentioned that a child should get breastfeeding at least for 2.5 years; which means there should be birth spacing." – a man currently using contraceptives from Badakhshan province IDI316

"The use of methods is permitted in Islam because Islam says that children should be breastfed for two years. So the family planning will allow me to breastfeed my child properly for two years. There will be no problem for us and we will be relieved." – a man currently using contraceptives from Kandahar province IDI413

Islam is great religion, the Holy Quran says you should give breastfeeding for your children continuously for two years. That is why the use of birth spacing methods is a very important issue. Otherwise when a woman gets pregnant, it affects the breastfeeding for the child." – a man currently using contraceptives from Kandahar province IDI635

"Islam says birth spacing is permissible because it is good for the child to have breastfeeding for 2 year and 6 month. It is permissible in a Hadith and the Mullah has said it is allowed." – a man currently using contraceptives from Kandahar province IDI333

- ◆ Us to ensure and protect the health and welfare of the mother – especially to the extent that this contributes to her ability to nurture the children well, meet her other family responsibilities (such as care for the husband and the in-laws), and fulfill her religious obligations as a Muslim

"Nowadays the scholars say it permitted in Islam to have 2 to 3 years birth space, it will help the mother to recover herself and will take care and nurture her children in a better way." – a man currently using contraceptives from Kandahar province IDI731

The use of birth spacing methods is permitted. If someone uses the methods, she is healthy and will have no problem to breastfeed for two years." – a woman currently using contraceptives from Jawazjan province IDI016

"It is allowed in Islam to use the methods; as it will help the mother to get healthy and recover herself." – a woman not currently using contraceptives from Khost province IDI926

"From the Islamic view spacing between two pregnancies is allowed. In the time of prophet Mohammad (PBUH) methods were not available but they did care. Now we have the methods and also want space between the children. If a mother gives birth frequently it is a danger for her." – a woman not currently using contraceptives from Jawazjan province IDI022

"If a woman is young and able to bear children, it is a sin for her to use birth spacing methods. If a woman is older and she uses, there is no problem." – a man not currently using contraceptives from Herat province IDI543

- ◆ Use to enable the family to fulfill the obligation/responsibility of providing for the nurture and development needs of their children (in line with what the father can afford to provide, and what the mother is able to withstand)

"According to religious leaders, those who are able to handle and take care of more children, then they are not permitted to use, whereas, those who cannot take care their children properly are permitted to use the family planning method." – a man currently using contraceptives from Herat province IDI531

"The use of birth spacing methods is prohibited in Islam; but in some situations Islam recommends birth spacing. If the childbirth takes place without any gap, then their education, feeding and clothing will be problems. Islam says that there should be two years birth spacing which is useful for the health of child and mother. She can manage all aspects of her child like breastfeeding and education." – a man not currently using contraceptives from Jawazjan province IDI044

"From Islamic view, the use of contraceptives is not permissible; unless we use when we are weak economically." – a man currently using contraceptives from Badakhshan province IDI335

"In case a couple can raise more children properly and provide them their needs, then it is a sin to use birth spacing methods. If they cannot manage this, then it is better to use the methods." – a woman not currently using contraceptives from Badghis province IDI221

Use to achieve spacing between pregnancies; and clear exclusion of method use to terminate a pregnancy already conceived or to permanently and irreversibly stop childbearing

"Mullahs say that if you have problems or you can't raise your children well, it is better to make spaces between your pregnancies. It is allowed in Islam and it will not be a sin. There should be two to three years space between pregnancies." – a man not currently using contraceptives from Herat province IDI547

"Islam permits use of birth spacing methods if it is based on a proper need, like to allow each child to be breastfed for two years. But permanent methods are not allowed in Islam." – a man currently using contraceptives from Kunar province IDI135

"According to Islam, if the use of contraceptives is really needed then it is not sin. We also have asked religious scholars and they said it has no problem if it is used for two or three years spacing of births." – a man currently using contraceptives from Herat province IDI534

- c)** The mandate and ability of Mullahs to teach about childbearing, child care and other family development undertakings

The understanding and decision making of families on contraceptive use is further influenced by the perceived ability and mandate of Mullahs to teach about birth spacing and about other aspects of family development; and by the regular and sustained practice of Mullahs with respect to such teaching as part of their regular work. Some of the issues indicated by Mullahs as appropriate to discuss (and often addressed by some Mullahs) in the context of religious worship and practice include:

- a)** Breastfeeding, child nutrition and child rights – the command to breastfeed for 30 months, so as to have children that will be strong for travel and for jihad; the value of breastfeeding as protection from pregnancy; and the problem of short intervals between births which limits the opportunities for full breastfeeding
- b)** Marriage and childbearing – the risk of marriage and bearing children too early, or getting children when too old; outside the age for ideal child bearing (18-35 years)
- c)** Nurture and education for children – to enable them have prosperous life; the responsibility of parents within the broader framework of Gods providence (with children and the means and ability to sustain them)
- d)** The high value of women and women's health in Islam – as the primary caretakers for children; exemption of pregnant women from fasting in Ramadan,

"Most of time I talk about the rights of men and women which starts from child. The rights of the child needs to be respected and given. I talk about the importance and value of a child in the circle of Islam through TV, radios, and at the Mosque. I have discussed about the child rights, birth spacing, breastfeeding, and raising the child and education of children. – a Mullah from Jawazjan province IDI061

"I always talk on weekly basis to the followers who come to my Masjid that you should consider birth spacing and use the methods because it is good for child health. We give information to the people during Juma prayers." – a Mullah from Badghis province IDI261

"For instance, in my brother's family, they have a baby boy who is not one year old, but my brother's wife is again pregnant since eight months; this is cruelty. One year or one and half year breastfeeding period of the first child is remaining; now they are in trouble. Although she took tablet but I think she was not taking it according to schedule." – a Mullah from Herat province IDI563

"I did not talk about birth spacing yet. Nobody has given me any task about it and nobody asked me to have discussion regarding this. As a result, I also have not paid proper attention to it." – a Mullah from Kandahar province IDI761

"We mostly emphasize about the proliferation and care for the children. Those who have weak family economy must get fewer children. Those whose economy is good they can have more children but they should take care of their education and nurture, feeding, clothing. Those whose life economy is weak, they should not get many children because they cannot take care of all their needs." – a Mullah from Badakhshan province IDI361

"Once a couple came and asked about abortion at 3 months of pregnancy. I said they should go to a doctor, abortion is not legal in Islam, but the pregnancy has many problem to the mother, she can go for operation." – a Mullah from Herat province IDI562

Discussions by the Mullahs and Mothers in law reflect deep appreciation of the unique value of breastfeeding in fertility and child health; largely grounded in Islamic teaching and in line with biomedical facts. Many Mullah respondents highlighted specific guidance in the Quran and in other Islamic texts about the appropriate duration of breastfeeding; as at least two years, ideally 35 months, and similar for the girl or boy child. It was acknowledged that some Islamic scholars indicate a longer period of breastfeeding for girls since they are weaker and will have a future responsibility of breastfeeding babies.

"Usually on Fridays I give awareness to people and also on some other days after prayer I gave awareness. We delivered messages that a family should maintain services to children properly and breastfeed child for a complete two years. It is good if women who give to birth without spacing to consider birth spacing; it is good for both the health of children and mothers. Their economic situation will better 100%, if they have more children they will not be able to maintain services for them such as food, clothing. That's why fewer children are good for the economy of a family." – a Mullah from Jawazjan province IDI062

"According to Imam Abu Hanifa, a child should be breastfed for at least two and half years; and after that time this right goes away. Prophet Muhammad (PBUH) says: Breastfeed your children for the complete period. This will enable them to become strong and they will not face problems while traveling or participating in Jihad in the future." – a Mullah from Herat province IDI561

"If the children are breastfed for less time, he or she will have weak bones. It will also cause mental and physical weakness in boys. Breastfeeding has many advantages for child." – a Mullah from Herat province IDI563

"The burning issue that we are confronted with today is the result of our failure in bringing up our children well. In Friday prayer, we should preach to the people to educate their children well so that they are not a burden on society. The children should not make troubles for the other people." – a Mullah from Samangan province IDI461

The Mullahs also noted the need for adequate spacing of births to enable realization of the breastfeeding duration for each child (discussed as a recognized right of the child in Islam. They further mentioned the pregnancy prevention effect of breastfeeding, and thus its value in ensuring maternal health and ability to care for the children.

"A child can be breastfed when there is space between births, so the space should be two years at least. This will enable the child to take the advantage of breastfeeding. If there is less space, the child would not be able to take benefit from breastfeeding for the complete period." – a Mullah from Herat province IDI561

"I have talked about this that a child according to the clear Ayah of Quran has the right to have breastfeeding for two years. If he has breastfeeding for two years, he will be strong." – a Mullah from Bamyan province IDI862

"We are living in a community that has problems. For instance, in my brother's family, they have a baby boy who is not one year old, but my brother's wife is again pregnant for another one since eight months; this is cruelty. One year or one and half year breastfeeding period of the first child is remaining; now they are in trouble. Although she took tablet but I think she was not taking it according to schedule." – a Mullah from Herat province IDI563

Most of the Mullah respondents indicate that they often speak about breastfeeding as part of their work in leading prayers and educating the people. Fewer among them acknowledge speaking about birth spacing to the same measure. The reasons mentioned for this limited speaking about birth spacing include:

- ◆ **Inadequate awareness and knowledge** – many Mullahs are not informed about birth spacing, because they lack the necessary sensitization and training, and do not have adequate and appropriate reference materials. Some have limited personal zeal to search for information on the subject, or to study the teaching and reference to the subject already present in Islamic materials. Very few among the Mullah respondents said that they have participated in any government-led dialogue and communication on Islam and family health.

- ◆ **Many people do not consult the Mullahs on the subject** – possibly because Mullahs are not considered the appropriate source of guidance and advice on the issue (their inadequate knowledge, availability of more informed health professionals, perceived opposition of Islam and Mullahs to use of the methods, etc.)

"I have not been told by people or organizations in any place that this is my responsibility. If I am advised by someone about this then it will be my duty to deliver the education to the people." – a Mullah from Bamyan province IDI861

"I never had talks about breastfeeding and family related subjects on Fridays. The problem is that some of Mullahs are careless about this matter and we often forget to address it. Otherwise there is a lot of information on it in Islamic books." – a Mullah from Herat province IDI562

"One of the obstacles in communicating to people about birth spacing is the lack of awareness of religious scholars about this issue. People don't refer to Mullahs and don't want to know about this matter. Religious scholars also don't notice this issue. If a person does not seek for information in the books they will not have information about an issue. So when people don't ask for information, Mullah doesn't search for it. That's why Mullahs have less knowledge about it. People don't ask Mullah about birth spacing method, its advantages and disadvantages, about breastfeeding benefits and other important points." – a Mullah from Herat province IDI561

"I have talked about giving birth without spacing and its consequences this year in a Friday prayer. I told the people to consider using birth spacing methods." – a Mullah from Bamyan province IDI863

"I have not talked about birth spacing so far. In my opinion, there are no documents or books for us that cover these methods; that is why I did not talk about it. There are no sources, materials and facilities for us to use and explain to the people about the advantage of pills or the benefits of injection. That is why we don't have concrete information about these issues to explain it well to the people. When people ask about an issue, they want conclusive information but we only tell them according to our knowledge from Hadith, not more." – a Mullah from Herat province IDI563

"When a seminar was conducted in Kunar province, I participated in it. I also went to Jalalabad, and two years ago we traveled to Bangladesh as well for such seminars." – a Mullah from Kunar province IDI161

3.3.3 Policy factors influencing use of modern contraceptives

a) Lack of a national population and development policy

After a long period of policy dialogue and drafting, the first draft National Population Policy for Afghanistan was completed in November 2016, and recognizes the strong interrelationship between population dynamics and socio-economic development. It aims to provide a framework for addressing the country's developmental challenges through structured management of its population dynamics including rapid population growth, by promoting human development for all Afghan citizens, prioritizing adolescents and young people, the girl child and women to bring high levels of fertility and mortality down, in line with development needs, and an orderly process of redistribution of the population and urbanization. It calls for an increase in the use of family planning as a key measure to reduce the high fertility rates, including adolescent fertility, short birth intervals and the associated high reproductive risks.

"There is a policy on birth spacing and family planning at the MoPH level. But when we wanted to have a policy on population control, there were lots of barriers and we were not allowed to develop a policy on population control. For instance the traditional and religious beliefs and misinterpretation were among factors that get in the way of developing such policy." – a government official at national level KII679

The draft policy addresses family planning from four main perspectives under each of the core policy areas: a) as a key element in population advocacy and awareness raising; b) as an issue of primary focus in the coordination of population programs and capacity building; c) as a core subject of measurement and monitoring in population data and research; and d) as one of the issues of focus in the mainstreaming of population dynamics and related issues in development planning across all sectors of society. The commitments in this draft policy are an important opportunity for future development of family planning programs and services in the country.

b) Coordination and management of the population and development policy process

Policy level respondents at national level in both government and development partners highlight the absence of an agreed and duly empowered centre to bring together all actors in the population and development policy process. This would help to coordinate their contribution to the process of development, implementation and monitoring of the policy and its results. It is noted that policy level engagement with population and development issues is relatively weaker in other government sectors compared to the health sector.

Sectors such as education, labour, information, culture, the academia and research institutions, etc.; are noted as needing mobilization and necessary capacity strengthening to effectively engage in this respect in a sustainable way.

"We need to have attention to population issues in education because this is an important element in having a strong, well-developed society. A high proportion of the Afghan population especially among women is illiterate because of having many children in a family. The families with many children might not afford to send all the children to school. Most of the time families will not send their daughters to school because they perceive that spending on girls is a waste of resources. In addition, we have a high number of school age children, which causes overcrowding beyond the schools standard and the ratio of teacher/ student, cannot be ensured and as a result the quality of education can be affected." – a development partner at national level KII672

"A specific institution is not present in the Afghanistan that deals with population related issues therefore I think awareness about population dynamics is not very good. Planning is not done based on the population projections. Also, we have three or more different types of estimates such as CSO, UN, EPI, WB. However, I think an entity which can deal with population dynamics and family planning can help in improving the use of population related data in planning and design of the different interventions." – a government official at national level KII675

c) Family planning leadership and coordination in MOPH and its effects

Many policy level respondents indicate that the current institutional arrangement for coordination of family planning activities at MOPH, and the capacity of the team in place for this function are not adequate for the necessary coordination of the different actors in family planning in the health sector such as private sector services, reproductive health team, health promotion and health information teams, etc. This central level weakness translates into limited operational linkage and technical support between the central MOPH leadership and coordination system for family planning, and the support systems at provincial, district and health facility levels. This results in weak family planning services in areas of management, implementation of existing policies and guidelines, support supervision, capacity building and quality assurance. Other areas of service support affected by such weaknesses include: a) ineffective coordination and inadequate quality assurance in branding and promotion of family planning products; b) inadequate resources mobilized and explicitly allocated for family planning support, and c) poor tracking of resources available and their efficient utilization to yield family planning results.

"Considering the MoPH, the issue of FP is well addressed at the policy and program level, but down at the implementation level, we have still problem. In most of the cases, the policies are developed at the MoPH central level, and those who implement the policy are not involved. Even, some of the implementers might not know about new policies, guidelines or procedures or the policies are not communicated to them. In some cases, they may receive the policy, guideline or procedure, but they do not have the skill to implement the guideline or procedures." – a development partner at national level KII671

"We have many stakeholders in family planning but the FP leadership function at the MOPH is a small department with limited resources so it is difficult to achieve greater goals. We need structural changes to make the team stronger and effective." – a government official at national level KII676

"Although the FP has been part of the RH directorate at the MoPH, the important positions there are often vacant. We do not have a strong team to work on the FP issue at the MoPH level. In my opinion, we need to do strong advocacy to strengthen this department and so that they can focus on resource mobilization and can integrate their services at the different level including community, health facility and other levels. Further, we should allocate enough resources to ensure proper monitoring by the RH department and ensure that the FP program is properly implemented." – a development partner at national level KII672

d) The family planning orientation and capacity of BPHS management contractors

Respondents note that some of the NGOs contracted to manage implementation of BPHS are not specifically attuned to family planning services as an essential element in health care, and thus lack capacity for effective integration of such services in the work they manage. This is further compounded by the limited technical guidance and support supervision provided to such contractors by the relevant MOPH teams. For example, there are no family planning indicators included in the monitoring of BPHS implementation, or in the results-based financing for health services included in BPHS implementation. As a result, there is limited management and service delivery support provided by some NGO contractors specific to family planning services at the different levels of the health system.

"The BPHS/EPHS prime focus is on maternal and child health services, therefore family planning and reproductive health is a priority agenda for the MoPH, donor agencies and technical partners. Acceptable level of resources has been allocated to this program, but these resources can be used more effectively and efficiently. However, constraints to implementation and accountability include: weak routine monitoring of family planning services by BPHS implementers, and insufficient supportive supervision on technical elements of family planning." – a development partner at national level KII674

"Sometimes the problem is with the method of selection of implementers, which quality and cost parameters are used in the selection. Sometimes the implementers would not budget all necessary activities for the FP implementation. There might be need for additional resource for improving the skills and training of staff. Likewise, we might need additional budget for a national program to support the FP activities that are beyond the capacity of health program implementing NGOs." – a development partner at national level KII671

e) Scale up of health and social services that help address population challenges

Many respondents indicate that the scale up of family planning and other health services has been addressed to a great extent. Improvement is also noted in education services and other community development efforts. Particularly notable is the increase in primary health care facilities and the services they provide, and the establishment of community level health services. The concern expressed by many respondents is on: a) limited focus on men as direct clients of family planning services – to truly serve couples not only women; b) many girls are still not going to school and they are instead married off when they are still very young; and c) current services are far outstripped by the fast population growth, especially in cities and some rural areas where people have returned as the conflict reduces.

"Those clinics which were established for 50 thousand populations, now these clinics provide services to 100 thousand populations. The number of clients and patients has increased. As well as we established a hospital for two lakh population. Now the population has reached to 3 or 4 lakh. The problem created is that the clients are not happy because they don't have access to the needed services, yet our doctor is overworked and tired." – a Program staff from Kunar province KII163.

"I think the health system has some good elements that encourage the use of family planning. For instance, supporting, training and deployment of more female health workers is one of the important intervention for improving reproductive health services and family planning. As we know the number of midwives reached from 300 to 2500 midwives and the number of female nurses is also increased." – a development partner at national level KII673

"The rapid population growth has resulted in increased malnutrition and stunting among children. This has resulted in an increase in morbidity and mortality." – a development partner at national level KII675

Many respondents note the growth in education services as an important opportunity to expand communication on family planning, to benefit staff and students in the schools, and reach their families and other community members. However, some respondents are concerned about the risks in such mass expansion of family planning education and possible misuse and wrong application of the knowledge.

"The FP is a very sensitive issue; hence we should be very careful about inclusion of FH in the school curriculum. As you know we already have a very high drop-out in secondary education, we should be careful not to increase the drop out even more, by introducing such sensitive issue. We need to avoid focusing directly on the issue of FP, but instead we can use other approaches to communicate the issues indirectly." – a development partner at national level KII672

"In my opinion, growth in population does not have beneficial affect such as educational system. If we have more population, the level of students will be increased therefore, they need in increasing more teachers. In addition to that, in health section could not response to all clients due to more population. We can control growth population with birth spacing methods." – a Program staff from Jawzjan province KII061.

"Rapid population growth in Afghanistan is not according to country economic status, and government planning and programs. Social services such clean drinking water, food, health services, transportation, optimal business opportunities and housing is not possible in cities with a high population. Employment may be difficult. It may force youths to leave the country, which negatively affect county economy, education, culture, political arena and cause insecurity." – a development partner at national level KII678

Another area of notable growth in mobilization, empowerment and service delivery and access is with respect to youth and their participation in governance, community development and social service delivery and use. Examples noted in this regard include: the development of the 2014 national youth policy, completion of the national youth strategy in 2016 and its initial utilization in programming and resource mobilization; the youth parliament as a mechanism to mobilize youth participations in governance; and focused expansion of youth focused services such as the youth helpline, youth focused health service support, and development and delivery of structured pre-marriage counseling as a national government-supported initiative.

f) Availability and use of data for population and development planning.

Respondents at national level note improved availability of data for population and development planning, such as the very first DHS done in 2015, the HMIS reporting on family planning services, and the socio-economic and demographic surveys done in some provinces over the last few years. However, some critical data elements are not fully included in current measurement and reporting systems. Examples mentioned are presented in Table 3 below.

Table 3: Illustrative data gaps in current measurement and reporting systems

| Data elements at population level | Data elements in service delivery reporting |
|---|---|
| Comprehensive knowledge of family planning – as a more precise predictor for translating knowledge into practice Practice of family level planning - including clear child bearing and birth spacing goals Experience of methods use – in line with each couple's child bearing and birth spacing plans | Records and reporting on method use that is linked to the couple's child bearing and birth spacing plans and goals Follow up and reporting on sustained use of methods and accomplishment of the couple's child bearing and birth spacing goals Follow up and reporting on adverse effects related to methods use Monitoring and reporting on media-based communication on family planning (e.g., methods promotion, method use experiences, etc.) |

"For example, the BPHS/EPHS prime focus is on the maternal and child health services. However, more effort is needed at the implementation level. Routine monitoring of family planning services and critical analysis of the available data can help proper implementation of policies/strategies and improve program." – a development partner at national level
KII674



4

Conclusions and recommendations

4.0 Study conclusions and recommendations

4.1 Study Conclusions

Conclusion 1: Couple communication on child bearing and birth spacing is virtually a universal experience among families in Afghanistan; but only starts after marriage, and after the couple has some children. There is recognition and respect of the mandate of couples to make decisions on child bearing and birth spacing. However, the child bearing and birth spacing considerations and decisions of couples are closely influenced by:

- a) The reality of early and arranged marriages experienced by many couples; which are often perceived as a continuation of the child bearing and family expansion aspirations of the couple's own parents
- b) The views and experiences of the couple's parents and other members of the extended family; particularly in the context of extended family living arrangements that remain dominant across the country
- c) The personal and extended family perceptions of Islamic teaching about child bearing and raising children; breastfeeding duration and the appropriate interval between births; and about the use of birth spacing methods by married women and men.

Conclusion 2: Family-level planning for child bearing and birth spacing is a common experience among Afghan families, as a largely informal and iterative process, undertaken together by a husband and his wife, his parents, and other members in their extended families.

- ◆ The planning process is largely reactive, as a response to: the number of children a couple already has; the perceived adequacy of boys among the children; and the problems experienced in bearing and raising them.
- ◆ There is evident and explicit participation of both women and men in the family-level planning for child bearing and birth spacing; largely based on the gender-based allocation of roles to women and men in the family context.
- ◆ Although the family level planning is based on clear economic and development considerations at this micro-level; there is limited evidence that this has been:
 - a) strengthened and utilized by community transformation and economic development initiative of government and other actors
 - b) clearly articulated and adequately promoted as an important element in family planning programs and services

Conclusion 3: FP awareness - most married people have some awareness about family planning, largely gained after marriage and clearly limited in scope and depth. The evident awareness is more about short-term contraceptives and less about natural family planning methods and the long acting and permanent methods. The awareness is also more focused on problems associated with use of specific contraceptives, and less explicit on the range and depth of benefits accrued from family planning.

- ◆ Awareness about family planning before marriage is recognized as important but largely absent. The ideal sources of family planning information for unmarried young people (including schools, Mosques, social media and other forms of mass media) are currently underutilized for family planning communication. However, there is keen and near universal support for greater utilization of such methods.

- ◆ Community level information sources (mainly FHA group members and CHWs) and health facilities are reaching many married people with family planning information. However, men are not adequately reached, especially because of:
 - a) Lack of male involvement in the FHA group approach at community level
 - b) Limited on no role for male health workers at health facilities in family planning communication and service delivery; and
 - c) The social norms that constrain male access to family planning communication and services by female health workers

Conclusion 4: Contraceptive use experience - many married women and men have experience of using contraceptives. The decision by a married couple to use contraceptives is often made when they already have a number of children, and is based on extensive consultation between the husband and wife, with other extended family members, and with other social associates particularly those with experience of method use.

- ◆ Two equally important categories of decisions underpin the use of contraceptives by families in Afghanistan:
 - a) Decisions whether or not to start using contraceptives, and which method to start with; and
 - b) Decisions about the continuation of methods use, the need to change methods, and on when and why to stop using methods
- ◆ There are strongly held social norms and perceptions about the value of child bearing and large family size; together with a perceived transition to greater acceptance and even preference for having fewer children through the use of contraceptives.
- ◆ The fear of adverse effects from contraceptives and actual experiences of health problems while using them, are a major barrier to uptake and sustained use of contraceptives.
- ◆ Most married people using contraceptives are getting them from public health facilities and CHWs; and to a less extent from private health providers and other sale points where specific contraceptives are stocked.

Conclusion 5: Family planning information provision and counseling is mainly the preserve of people deployed in maternal health services at health facilities, CHWs and FHA group members; is primarily focused on enrolling married women to become users of available birth spacing methods by introducing the methods and how to use them.

- ◆ There is limited follow up communication and counselling support to monitor method use experience and action as necessary; and no structured role of users as experienced communicators or peer counselors on methods and their use.
- ◆ The system-level dialogue on family planning reflected in the study discussions includes the three related concepts: family planning, birth spacing and contraceptive use, often used interchangeably depending upon the context of use. However, it is not always clear to all parties which one of these three meanings is intended in the different contexts where the terms are used; which may result in misunderstanding and misinterpretation. Yet, all three terms may have a legitimate and complementary role in describing the complex and multi-faceted process of child bearing and its management.

Conclusion 6: Provision of family planning services at community level and in health facilities is closely integrated into other health communication and health care activities that target or closely involve women. Although the role of men as family planning clients in their own right, and as critical supporters to their wives as the index clients, is well recognized, it is not adequately reflected in the current planning and delivery of family planning services.

- ◆ There is limited integration at planning level and little linkage in promotion and delivery of programs and services for family planning and other development initiatives such as education, empowerment of women and girls, community driven development, etc.
- ◆ Provision of long term family planning methods is largely limited and inadequate to meet the evident demand for such services. The main constraints in this respect include:
 - a) Inadequate capacity of health providers, especially at the primary facility level to administer the methods;
 - b) Limited infrastructure and equipment to support delivery of such methods; and
 - c) Supply chain bottlenecks with respect to specific methods such as implants

- ◆ Provision of family planning services in the private health care sector is not adequately linked to the management and support opportunities that are available to services in the public healthcare sector. The private sector is an important source of family planning services for many people as the first and often the only preferred source, or as a complement to public health sector services; especially in situations of methods stock out. However, the cost of services is a major barrier to some would be users.

Conclusion 7: Policy support for family planning - the current health policy position in Afghanistan, as reflected in the 2016-2020 national health strategy and the 2017-2021 national RMNCAH strategy is adequate to support and ensure design and implementation of effective birth spacing/family planning services. There is evidence that progress is already realized in addressing some of the elements in this regard, such as: scale up of family planning and other health services, improvement in education services and other community development efforts, and availability of data for population and development planning, such as the very first DHS done in 2015, the HMIS reporting on family planning services, and the socio-economic and demographic surveys done in some provinces. However, progress is less evident (or completely absent) with respect to other elements such as:

- a) Articulation AH strategy and the specific family planning elements therein
- b) Translating the awareness about the link between population and development into concrete cross-sectoral engagement in planning and delivery of development programs and social services
- c) Coordination across the development and service actors especially at province, district and facility/community levels
- d) Some critical data elements are not fully included in current measurement and reporting systems

Conclusion 8: Health and development coordination - There is absence of an agreed and duly empowered centre to bring together all actors in the health, population and development policy process at national level. The policy level engagement with population and development issues is most developed in the health sector; and relatively weaker in other government sectors such as education, women in development, labour, information, culture and religious affairs, and the academia and research institutions.

- ◆ The current institutional arrangement for coordination of family planning activities at MOPH, and the capacity of the team in place for this function are not adequate for the necessary coordination of the different actors in family planning in the health sector such as private sector services, reproductive health team, health promotion and health information teams, etc. This central level weakness translates into:
 - a) Limited operational linkage and technical support between the central MOPH leadership and coordination system for family planning, and the support systems at provincial, district and health facility levels; and
 - b) Weak family planning services with respect to management, implementation of existing policies and guidelines, support supervision, capacity building and quality assurance.

Some of the NGOs contracted to manage implementation of BPHS are not specifically attuned to family planning services as an essential element in health care, and thus lack capacity for effective integration of such services in the work they manage. This is further compounded by the limited technical guidance and support supervision provided to such contractors by the relevant MOPH teams.

4.2 Study recommendations

4.2.1 Recommendations for Operational and Mid-level Action

Government leaders and managers at province and district levels, together with NGO contractors managing implementation of the BPHS should empower and support health facility managers and other actors in health and socio-economic transformation at community level to:

1. Package and deliver family planning communication and services as a couple-focused, deeply interactive and adequately iterative process that is:
 - a) Fully integrated in the education curricula and co-curricular programs of all education institutions that reach adolescents and young adults
 - b) Included as an integral element in delivery of the government-supported pre-marriage counseling program and other opportunities for marriage preparation and support for young people

- c) In consideration the unique context and experience of each couple; and address their specific influencers in terms of perceptions, engagement and decision making with respect to childbearing, birth spacing and contraceptive use
 - d) Inclusive of women and men with experience using contraceptives as core communicators and encouragers in the communication delivery process
 - e) Fully supported with necessary monitoring of changes in the context of couples using contraceptives, and the implications of such changes with respect to method choice and change, planned method discontinuation, and other adjustments in the use process.
- 2. Work closely with community elders, Mullahs and other social service and development programming actors at operational level to promote utilization of the family-level planning process as an important entry point and platform for comprehensive consideration of child bearing and birth spacing goals for each family, in line with their social and economic context, their faith considerations, and their long-term development and transformation objectives
- 3. Enhance attention to reaching men with family planning information and services in health facilities and at community level by:
 - a) Expanding the FHA group approach to include participation of men
 - b) Providing necessary institutional support (e.g., training, deployment and work guidelines, due attention in support supervision, etc.) to enable male staff in health facilities to effectively and sustainably participate in provision of family planning services to male clients, and where the social and operational context permits, to couples
 - c) Adjusting the service delivery layout and client flow in MCH services to enhance attendance and satisfaction of male clients, including provision for space and time for couple consultation with midwives, and specific attention to male problems as an integral element in family-focused MCH services
- 4. Monitor and promptly address FP adverse effects: continually review and address the problems experienced by clients over the period when they use contraceptives. Specific attention in this regard should be paid to:

- a) Health problems that may be concurrent with use of contraceptives but are not directly attributable to the specific contraceptives in use, to dispel inaccurate attribution of such problems to the methods
 - b) Health complications as a result of using some methods, which may require specialized treatment or referral
 - c) Perceived effects of contraceptives that affect the ability of clients to perform regular tasks
- 5. Address all steps and options in the contraceptive use decision making flow chart that has been expounded in this study. This framework should be adopted as an additional tool in planning for family planning service delivery, capacity building, support supervision and reporting.
- 6. Address identified service delivery bottlenecks to ensure sustained and quality delivery of family planning services; with priority focus on:
 - a) Improving family planning commodity stock outs in public sector by establishing a mobile technology based stock management system and timely provision of the family planning supplies.
 - b) Designing capacity building strategies to improve counseling skills of the health care providers so that clients are properly counseled on method choice and effective use, and on management of problems associated with method use.
- 7. Enhance cross-sector collaboration based on the integrated health and development framework to ensure family planning linkage and integration in other development and social service sectors
- 8. Ensure systematic and adequately supported scale up of delivery for long term family planning methods, by analyzing and addressing the specific bottlenecks to this aspect of family planning services in each sub-national governance and operational context.
- 9. Private health providers and medicines sale points should be included in the mainstream mechanism for planning and provision of family planning services; addressing aspects such as:
 - a) Supplies procurement, distribution and quality control;
 - b) Supervision, records and reporting management;
 - c) Control of service and product prices to ensure equity in access to family planning services to all

4.2.3 Recommendations for National Level Action

1. The relevant government development planning institution(s) at national level, with necessary support from development partners, should:
 - a) Mobilize all stakeholders and facilitate consensus building on the appropriate coordination mechanism for integrated health and development at national and sub-national levels; and ensure due operationalization of the mechanism at all levels
 - b) Support strengthening of the family planning unit within the MoPH by expanding its scope and provision of needed resources so that it can become a fully functional entity within the MoPH.
 - c) Support development of a comprehensive and costed implementation plan for the national RMNCAH strategy
 - d) Coordinate the revision of data collection and reporting on population and development indicators at all levels to ensure availability and utilization of adequate data to address the data gaps illuminated in this study
2. The MOPH, in collaboration with relevant health development partners, should
 - a) Review and adapt the contracting and supervision guidelines for NGO implementers of the BPHS to ensure appropriate and adequate coverage in the planning, implementation, monitoring and reporting on family planning services at community, health facility and sub-national levels.
 - b) Work with MoHE on improving the curricula in health training institutions for doctors, midwives, nurses, etc., so that all new graduates have the required skills and knowledge about all relevant family planning methods.
 - c) Advocate for inclusion of family planning in the high school curricula.
3. The MOPH lead team on family planning services, in close collaboration with other MOPH Units and necessary support from health development partners should develop and ensure utilization at all levels of a family planning programming and communication framework that explicitly and adequately addresses the three related concepts: family planning, birth spacing and contraceptive use, that are often used interchangeably depending upon the context of use.

4. The MOPH, in close collaboration with MOHRA and with necessary support from development partners should coordinate the development and implementation of a concrete multi-level mechanism for sustained engagement and systematic delivery of population and development communication, promotion and support actions through Islamic institutions and religious scholars.



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