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**An Analysis of Policy and Social Factors Impacting The Uptake of Sexual and
Reproductive Health Services in Kabul, Afghanistan**



A Thesis presented to the School of Medicine, Pharmacy and Health for the degree of

Doctor of Philosophy

Manizha Hadi MD, MSc.

June 2016

DECLARATION:

I declare that this Thesis has been composed by myself, and that the work of which it is a record was performed by myself. The Thesis has not been admitted in any previous application for a degree at this or any other university. All sources of information have been specifically acknowledged.

Acknowledgments

It is with genuine pleasure that I would like to express my gratitude to my supervisors Dr. Sharyn Maxwell and Dr. Kate Hampshire for their support and thoughtful insights over the past four years. You have checked many drafts of my research critically and tirelessly and have been a great source of support for my professional development.

Dr. Sharyn Maxwell, your guidance and encouragement was invaluable. I would like to thank you for your academic support to help me think critically and your enormous emotional support through the ups and down of my research process and belief in my ability in achieving my research objectives.

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Lastly, wholehearted thanks to my family members who have been the motive behind my PhD progress and achievements over the years. They encouraged me to pursue a path to achieve a higher level of knowledge, and to contribute to solutions that can influence the physical and social health and well being of women.

Abstract

Title:

An analysis of policy and social factors impacting the uptake of sexual and reproductive health services in Kabul, Afghanistan

Question:

What factors at individual, health service provision and system levels are influencing sexual and reproductive health (SRH) service uptake?

Rationale:

In many Afghan ethnic groups, girls and women face heavier risks of disease and infection than men. Their diminished economic and social status compromises their ability to select healthier life strategies and access to sexual reproductive health (SRH) services. The Afghan government estimates a high maternal mortality ratio (327/100,000 live births) in Afghanistan. However, due to inadequate reliability of data, the true maternal mortality and morbidity ratio remain unknown. A deeper understanding of the policy and social factors that impact on poor SRH service uptake would help the development of applicable and successful SRH Policy and frame applicable and appropriate approaches for sustainable SRH service uptake in Afghanistan.

Method:

It is a qualitative policy analysis using the 'Broader Framework of Thinking' by Walt and Gilson (1994) and a variety of data collection methods. Data was collected from 450 participants (Patients 223, Family members 72, Health service providers 63, Governmental staff 31, Coordinating organisation staff 17, Religious leaders 11, Health-promoters 13, Psychosocial counsellors 20) by conducting interviews, focus group discussions, participant observation, life narratives, document reviews and an audit of medical records.

Findings:

My results show the key factors underlying women's poor health were a lack of knowledge about SRH, poor communication, and a lack of honour and trust both between individuals and within the health system. In addition, research findings highlighted that depression, multi-pregnancies, childbirth complications, anemia, malnutrition, sexually transmitted infections and interpersonal violence were routine for women. It clearly shows gaps within SRH Policy design and implementation and health service provision. These gaps are associated with social factors, which negatively impact on access and utilisation of proper SRH services

Conclusions and Recommendations:

This research analysed national reproductive health Policy (NRHP) and explored the impact of multifaceted social factors on SRH service uptake. In complex health systems recommending solutions require distinguishing between types of problems and a specific time-scale to improve SRH service uptake.

Abbreviations

AMS	Afghanistan Mortality Survey
ANC	Antenatal Care
ANDS	Afghanistan National Development Strategy
BPHS	Basic Package of Health Services
C/S	Caesarean/ Section
CARs	Central Asian Republics
CDC	Centre of Disease Control
CEDAW	The Convention on the Elimination of All Forms of Discrimination Against Women
CHCs	Comprehensive Health Clinics
CHPs	Community Health Providers
CSO	Central Statistics Organisation
DFID	The Department for International Development
Doc	Doctor
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
FGM	Female Genital Mutilation
FP	Family Planning
GP	General Practitioner
HIV&AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HSPs	Health Service Providers
IBSS	Internationals Bibliography of Social Science
IEC/BCC	Information Education Communication/ Behavioural Change Communication
ICPD	International Conference on Population and Development
IPC	Interpersonal communication
IPD	In Patient Department
IRB	Institutional Review Board
IUD	Intra Uterine Device
MDGs	The Millennium Development Goals
MHD	Mental Health Department
MICS	Multiple Indicator Cluster Survey
MMM	Maternal Mortality and Morbidity
MMMR	Maternal Mortality and Morbidity Ratio
MMR	Maternal Mortality Ratio
MoE	Ministry of Education
MoPH	Ministry of Public Health
MoWA	Ministry of Women Affairs
MSF	Médecins Sans Frontières / Doctors Without Borders
MW	Midwife
MWs	Midwives
NGOs	Non Governmental Organisations
NRH	National Reproductive Health
NRHP	National Reproductive Health Policy
NRVA	National Risk and Vulnerabilities Assessment
OPD	Out Patient Department
OHCHR	Office of High Commissioner for Human Rights
PHR	Physicians for Human Rights
PID	Pelvic Inflammatory Diseases
PNC	Postnatal Care
Pt	Patient
R	Researcher
RH	Reproductive Health
PPH	Post Partum Haemorrhage
RHD	Reproductive Health Directorate
RTIs	Reproductive Tract infections

SBAs	Skilled Birth Attendants
SC	Save the Children
SCA	Swedish Committee for Afghanistan
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHRs	Sexual and Reproductive Health and Rights
STDs	Sexual Transmitted Diseases
STIs	Sexual Transmitted Infections
TBAs	Traditional Birth Attendants
UN	United Nations
UNAMA	The United Nations Assistance Mission in Afghanistan
UNDP	The United Nation Development Program
UNFPA	The United Nations Population Fund -
UNHR	United Nations Human Rights
UNICEF	The United Nation Children's Fund
UNODC	The United Nations Office on Drugs and Crime
USDs	US Dollars
USAID	United States Agency for International Development
UTIs	Urinary Tract Infections
VAW	Violence Against Women
WB	The World Bank
WHO	World Health Organisation

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Chapter One

1. Research Overview

1.1. Thesis Title

An analysis of policy and social factors impacting the uptake of sexual and reproductive health services in Kabul, Afghanistan

1.2. Rationale

Through the analysis of policy and social factors, this research explores barriers to Antenatal Care (ANC), Postnatal Care (PNC), Family Planning (FP) and childbirth health services and how Afghan women in different ethnic groups negotiate these (successfully or otherwise). The aim is to identify the means to begin timely interventions to reduce the maternal mortality and morbidity ratio.

1.3. Research Questions and Objectives

This research focuses upon understanding the uptake of Sexual and Reproductive Health (SRH) services in Afghanistan. My research aims are to consider:

1. What are the main contextual barriers (policy, geography, recent history and institutional) to SRH services uptake?
2. What are the main social factors that impact on SRH seeking behaviours?
3. What are the roles of members of the family in influencing women seeking either institutional SRH care services or more traditional care?
4. How do the existing structure and status of health system and Health Service Providers (HSPs) help and/or hinder women's willingness to seek or source SRH services?

In order to answer these questions, the specific research objectives are to:

- Understand how policy-makers view their roles and responsibility for implementing SRH?
- Identify patients' and health service providers' specific perspectives on each other and the SRH services received/provided.
- Frame applicable and appropriate approaches for sustainable and accessible SRH service uptake.

1.4. Why This Research Is Important?

Universal access to SRH is one of the key targets of sustainable development goals (SDGs). Sexual and reproductive health has only been recognized and attention specifically focused on improving outcomes over the last 23 years, particularly in low- and middle-income countries (Chandra-Mouli & Lane 2015, UN/SDGs 2015).

Evidence shows that a low level of SRH services uptake is a major cause of a high level of maternal mortality and morbidity, sexually transmitted infections (STIs), unintended and multiple pregnancies and gender-based violence, particularly in low-income countries (UNFPA 2015a).

Sexual and reproductive health has long-term impacts. It is critical for not just for the health of individual women, but also the health of nation. If the SRH service uptake is not improved, family welfare and the future workforce are a threat. In other words, it will have major impact on future generations because of the high ratio of mortality and morbidity among women of childbearing age.

Very few empirical studies have explored multifaceted ways to improve SRH service uptake in low-income fragile or conflict-affected contexts. Moreover these studies failed to effectively produce unifying and applicable interventions. This is because, although much focus on providing technical and financial support to the SRH system in many low-income fragile countries, technical measures to improve aspects of health system are always interpreted in place (Chandra-Mouli & Lane 2015, Mertus 2000).

In Afghanistan, many girls and women face heavier risks of disease and infection than men due to their diminished economic and social status which compromises their ability to achieve safer and healthier life status (Waldman 2008, Refworld 2012). The Afghan

government estimated a high maternal mortality ratio (MMR) of 327 per 100,000 live births in Afghanistan, corresponding to a lifetime of 1 in 32 women dying from reproductive complications (AMS 2010). However, due to inadequate and unreliable data, the actual extent of maternal mortality and morbidity ratio and the full range of factors that impact on women's poor SRH and well-being remain unknown. Indeed, the statistics are inconsistent between various reports of different authorship (UNDP/Afg 2015, Zeid 2015, Sen & Mukherjee 2014, Sen & Govender 2014, Tangcharoensathien 2014) due to difficulties in accurately assessing the true ratio and that itself is part of the problem for SRH service uptake improvement in Afghanistan. Thus, despite the inflow of significant international humanitarian aid following the end of the Taliban regime, and some reduction in maternal mortality ratio from earlier estimates, more recent estimates are still very high.

It was therefore important to explore and better understand the complex array of particular factors impinging on reproductive health service uptake in Afghanistan, and how these play out within the health services and in the lives of individual women and their families.

1.5. Why This Research Is Of Interest and Importance To Me?

I am a qualified doctor, trained at the Medical University of Kabul, specializing in Obstetrics/ Gynecology and Sonography. I have about 12 years work experience in social development, gender-focused health programs and management and have worked with national, international, UN and US donor agencies.

I realized earlier that my work as a physician is inadequate because I was only able to provide health care services to a small number of patients. I also acknowledged that there is a necessity to identify why gynecology or obstetric care services have not been well supported in the Afghan context. Therefore, I began working as a health program producer with British Broadcasting Corporation Afghan Educational Project (BBC/AEP) to reach a larger group of people in Afghanistan. Group discussions I had with community members regarding their health issues encouraged me understand in-depth their perceptions and experiences of health care.

Later, I worked as Senior Health Projects Specialist in a United States Agency for International Development (USAID) project I oversaw the health management information system, and implemented numerous systems for monitoring and evaluation of community

activities, including conducting assessments and surveys. This gave me an insight into some of the inadequacies of the health system.

I have also worked with UNESCO as a part-time HIV&AIDS advocacy consultant. Conducting awareness workshops with high schools teacher and university lecturers, on HIV & AIDS prevalence in Afghanistan and seeking to add this topic to the educational curriculum, I realised the inadequate awareness of and pervasive influence of sociocultural and religious beliefs on people's perception of this disease. People's reluctance to discuss issues related to sexual health and the factors behind the transmission of HIV (regardless of their education) made implementation of awareness programs difficult.

Understanding Afghan sociocultural and religious beliefs, I was reluctant to translate the UNESCO 'HIV&AIDS Advocacy Toolkit' guide for teachers (UNESCO 2002) and 'Preventive Education Information Kit' for school teachers (UNESCO 2008) into the Afghan national languages, which are Dari and Pashto. Indeed, this advocacy toolkit was developed in Bangkok and there was much information in it, which would not be received well in Afghanistan. Hence I only adapted a few pages out of around 100 pages of the guidance and information kit and had to develop an alternative HIV&AIDS information kit and design picture messages, which took Afghans values and practices into consideration.

The desire to better understand the above issues, contribute to finding solutions that could impact on the improvement of SRH service uptake and have a positive impact on the future lives of individual women led me to seek further education and research opportunities. I obtained an Afghan Women's Scholarship in 2011 to do a Master's degree in Public Health and Policy at Durham University, School of Medicine, Pharmacy and Health. I conducted an exploration of ANC guidelines and services in Afghanistan in my Master's degree. However I recognised that a full understanding of the situation on the ground would not be achieved within the confines of a master's dissertation. Further, achieving the 'Health and Well-being Prize for the Best Master's Degree Dissertation' and obtaining a PhD research scholarship provided me with an opportunity to extend my knowledge. In fact, my MSc. dissertation project provided the foundation knowledge to undertake PhD research to answer the wider aims and objectives stated above.

My background training and experience were crucial for this project in two aspects. First, it helped me understand the magnitude of the SRH issues and the sociocultural influences on women's SRH and well-being. Second, having worked extensively in the reproductive health sector in Afghanistan and understanding the Afghan context, tradition and

languages, I was in an exceptional position to undertake this research and reflect on relevant findings.

1.6. Structure of The Thesis

Using analysis of policy and social factors, this research explores barriers to SRH service uptake in Kabul, the capital of Afghanistan. I begin by exploring the position and perspectives of WHO and other health entities in advocating SRH improvement in developing countries, and especially in fragile states like Afghanistan. Through application of 'The Broader Framework of Thinking' Model by Walt and Gilson (1994), analysis of the Afghan Reproductive Health Policy, I then review the policy context, content, role of actors (individuals, HSPs and senior health staff), policy development and reform process. Next the social factors influencing the health seeking behaviour of Afghan women, the provision of health services and the wider health system are explored. Lastly, applicable recommendations around SRH service uptake at the individual, HSPs and health system levels are discussed.

Chapter Two

2. Research Methodology

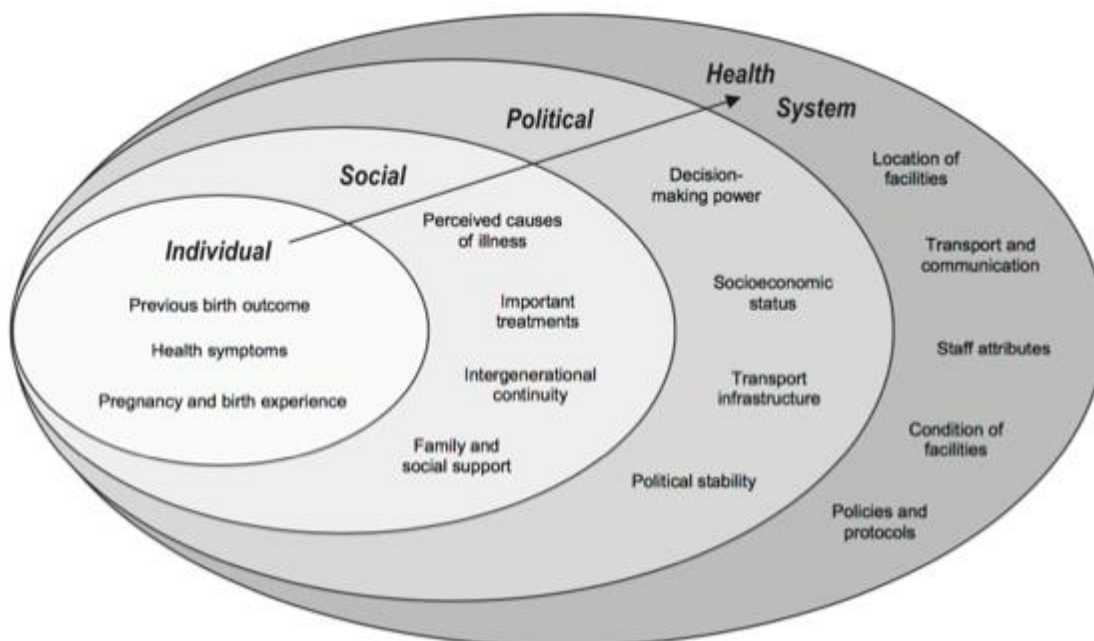
This policy analysis emphasises the social contexts in which the policy is both shaped and applied. This chapter outlines the theoretical approach, methods, samples and locations of the completed research. A discussion of data analysis and the ethical challenges of conducting this research are provided at the end of this chapter.

2.1. Theoretical Frameworks

A number of possible theoretical frameworks were identified at the initial stages of research to be applied as an analytical framework. I was initially enrolled in Anthropology and as such, considered numerous theoretical framework for organising my research strategy approach and analysis.

To analyse the multi-layered impacts of society, politics, and health system powers on individuals' bodies my initial proposed framework was the 'Multi layered, person-centred' framework (Wild 2010). This framework (Fig. 1), underlines the influence of various aspects on health system.

Figure 1. A ‘Multi-Layered Explanatory’ Model



Source: (Wild 2010)

This framework is applied in critical medical anthropology studies (Andersen 1995, Turner 1992, Scheper-Hughes and Bourgeois 2004) to illustrate the obstacles at various levels that hinder women’s access to effective SRH care services.

Ostensibly, the framework permits exploration of women’s lived experiences and the influence and the formation of sociocultural and political bodies, which could unmask the unequal distribution of the social determinants of health and gender inequalities (Singer 1995). This framework was developed for a specific setting and only focuses on the impact of multi-layered aspects on SRH utilisation. Hence, it does not take account of the SRH policy development and implementation process, family members’ perspectives, cultural variables, gender inequalities and reproductive health rights, to expose the dominance of such powers.

Initially, this was my overarching method and even within that I was thinking particularly through individual actors’ dynamics. However after being registered with the department of Health Studies in School of Medicine, Pharmacy and Health, I realised that I wanted to be more public health oriented in my approach, as it was more in line with my professional training and skills and my desire not just to understand but to seek actively make a difference.

There were some frameworks, which were widely used in community development and public health. Some of them seemed to be applicable to the Afghan context. One of these was the 'Asset-Based' approach, which identifies and uses what people and communities have, rather than what they do not have, in devising strategies for improving communities. Community development assets can include the skills of local residents, the power of local associations, and the supportive functions of local institutions (Foot 2012, Foot & Hopkins 2010).

Unlike the 'Asset-Based' approach that operates from a positive approach, in 'Deficit-Based' approach individuals' roles and knowledge are overlooked and people are viewed as passive health service utilisers or even causes of the problem. Such 'Deficit-Based' approaches mainly identify an individual's and or a community's shortcomings and focus on improving service provision (Wormer & Davis 2008).

Both 'Asset-Based' and 'Deficit-Based' approaches do not include an understanding of effective health systems and policies. In addition, these approaches can be fully utilised in a context where health policies are already implemented and focus is made only on identifying what individual actors have already done and what additional progresses should be made. Both approaches are useful therefore but they are incomplete in providing an overarching analytical framework for this Thesis.

An alternative approach, the 'Human Rights-based' approach (Yamin 2010, London 2008, WHO/HRP 2014) addresses global health inequalities and advocates human rights, which allow people to control their health and body i.e. pregnancy, forced marriage, domestic and sexual violence. This model promotes a mechanism for accountability and equity (Daniel 2009). However I realised that the 'Human Rights-based' approach alone also could not support policy analysis, development and implementation and does not address health service improvement. Banik (2010) and Kindornay (2012) also argue that the absence of sustainable political commitments and dependency on international aid discourages translation of this approach into practice. In order for the 'Human Rights-based' approach to be robust and effective in this research, I would need a way to tie up 'Human Right-Based' approach with 'Asset-Based' approach or 'Multi layered' framework.

Furthermore, according to the Commission on Social Determinants of Health Report (Sommer 2015, Viner 2012, WHO 2008), in order to make real change to health systems and improve the health seeking behaviour of the population, mainly women, there is a need

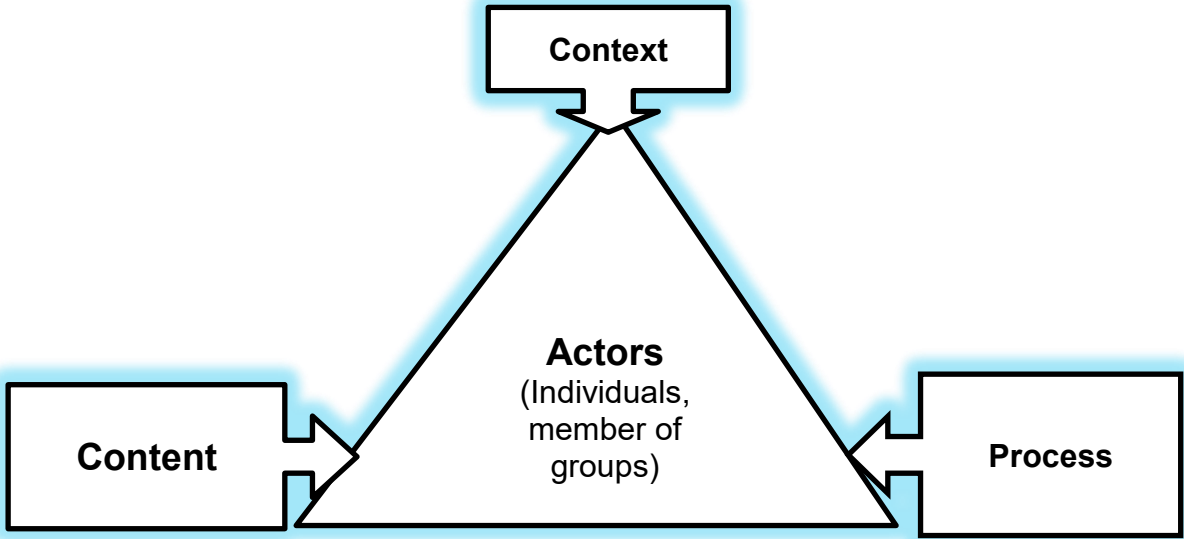
to address the social determinants of health (SDH). The Social Determinants of Health theory also offers implications for policy reform and implementation, although it is challenging for policy-makers to address multifaceted SDH within complex health systems (Exworthy 2008). Indeed, SDH poses many challenges to the policy process. For instance, it is difficult for policy-makers to develop solutions in a specific time-scale. Moreover, there is a lack of inter-sectoral and inter-organisational coordination and commitment to implementing policies to address SDH (ibid). In low-income countries like Afghanistan, health policies have often been adapted from high-income countries, which makes addressing SDH in a very different context significantly challenging.

Some research papers note the use of proximal SDH for improving SRH. Proximal determinants mainly explore issues around individuals' health seeking behaviours and their relationships with family and society members (Viner 2012, Sommer 2015). Other papers stress the incorporation of structural determinants, which include political, economic, cultural, education and other social welfare systems along with the proximal determinants and health policies in order to obtain a larger scale SRH outcome (Parker 2000, Kerrigan 2006, Aggleton 2012, Blankenship 2006, Gupta 2008).

Both proximal and structural determinants of health in research on SRH service uptake can be explored in the Afghan context with the use of the policy analysis triangle, known as the 'Broader Framework of Thinking' by Walt and Gilson (1994). This framework (Fig.2) is applicable for health policy analysis and the identification of the broader extent of health issues in many low-income countries (Gilson & Raphaely 2007).

Indeed, SRH Policy development processes, discrepancies and achievements, the role of actors in the SRH system, health provision and uptake and the context of SRH Policy implementation (Hill & Hupe 2002) are intertwined. Therefore, using this framework (Fig. 2) would help me understand the policy context, content, power of actors (individuals, HSPs and senior health staff), policy development and reform process (Walt & Gilson 1994, Buse 2012) because it captures the interconnectedness of all these factors.

Figure 2. The 'Broader Framework of Thinking' Model



Source: Walt and Gilson Policy Analysis Model (1994 p. 354)

In many developing countries, during the policy development and reform processes, policy-makers ignore the content and each actor's role in the effective implementation of the policy (Walt & Gilson 1994, Gilson & Raphaely 2007 & 2008, Buse 2012, Walt & Shiffman 2008, Brugha & Varvasovszky 2000, Shiffman 2007). Using the Walt and Gilson's model would allow me to identify some of the power bases and role of many different actors (policy-makers, MoPH senior staff, international organisation's staff and funding organisations' representatives) involved in the policy development, reform process and in implementation (Roberts 2004, Buse, Mays & Walt 2005).

Moreover, applying the 'Broader Framework of Thinking' model would help me understand whether policy development and reform were conducted to focus on the actors' (individuals, community or HSPs) needs, or if there was some political settlement and influencing of any interest groups. This therefore becomes the primary approach of this thesis. However my reflections in applying Gill's model were also informed by my awareness of the factors highlighted by the alternative approaches discussed above, which helped me think about the social and individual factors as well as context and the policy development process and implementation.

2.2. A Rationale for the Selection of Research Methods and Document Analysis

To obtain in-depth understanding of each of the four specific elements of the 'Broader Framework of Thinking' a range of data collection methods was necessary.

A review of the socio-scientific literature, combined with peer reviewed and grey literature from a variety of sources were used to explore SRH related issues in the Afghan context. For the purpose of policy development process analysis; demographic, internal, unpublished and undistributed government documentation (mostly reproductive health-related policies and strategies since 2002 to the present), were obtained from the MoPH/RHD. Some guidelines, reports and fact sheets were reviewed from international organisations including WHO, World Bank and other UN organisations' websites.

Content is another element of the 'Broader Framework of Thinking', which requires technical data collection. Assessment of content requires both examining the policy itself and using the technical and social data collections to assess the applicability and adequacy of the policies contents (including what elements of SRH care are missing from

the policy content). The content comes from these sources: statistical data (ANC, PNC, FP and maternity visits report, patients' tally sheets and medical records, monthly and quarterly activity reproductive health service reports) from HMIS office (Health Management Information System), two district hospitals and two comprehensive health clinics were obtained, reviewed and audited. Literature from global and low-income fragile states' SRH policies was reviewed. Publically undistributed documents related to SRH services and reproductive rights, in Pashto, Dari and English languages, were obtained from MoPH, a number of non-governmental organisations, human rights office and social activists.

To shed light on unrevealed factors affecting SRH services uptake, information was obtained from various actors through the application of different methods (Kitzinger 1995, Moriarty 2011, Creswell 2007). Participant observation and semi-structured interviews were initial methods of data collection. Life narratives were compiled from a number of participants who wished to talk in more depth about their life experiences and stories. Focus group discussions (FDG) were included to explore relevant health service providers', policy makers, MoPH /RHD staff and implementing organisations' staff's viewpoints. Focus Group Discussions were also conducted with religious leaders and local men to understand their point of view of factors that impact on reproductive health seeking behaviour and improvement of SRH care provision and uptake. In addition, I conducted 31 follow up interviews with my selected participants (pregnant women, mother-in-law, husband, health service providers etc.) with in the health facility and in their households to obtain deeper reflections on the SRH improvement suggestions and also to identify the opinions of those participants who were not willing to discuss publicly or had private opinions that they were not happy to admit in front of others. This helped me to determine what else people think but may not want others in their immediate vicinity to know.

2.3. Literature Search

Publically available (primarily peer reviewed) documents were obtained by searching appropriate databases (International Bibliography of Social Science (IBSS), Ovid Medline, ProQuest Social Sciences Premium and ProQuest dissertations and theses, Web of Science, JSTOR, Science Direct).

Selection criteria included English language data because there is scarcity of relevant published data in Dari and Pashto languages. Some documents were related to health and social science and some were ethnography based.

2.4. Key Words Applied

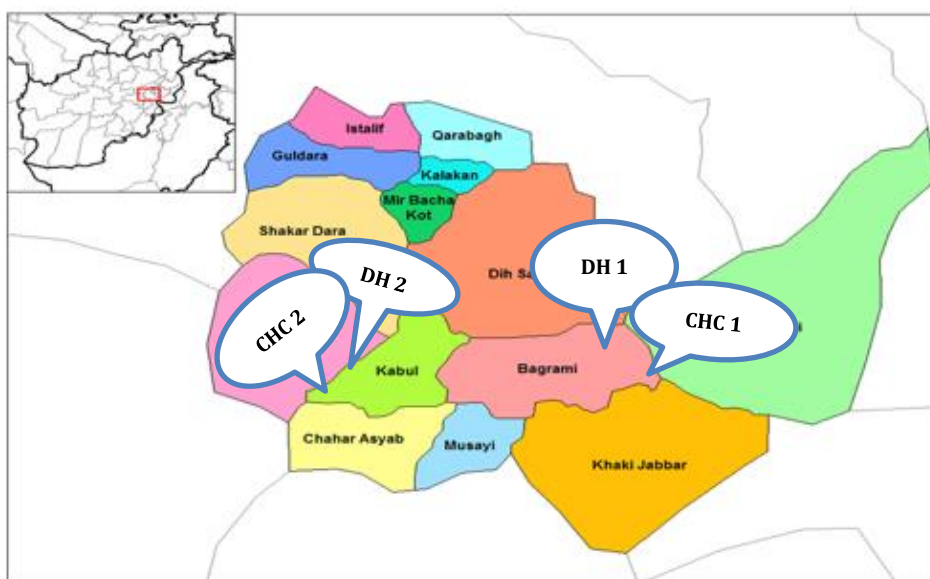
A number of keywords were applied: Sexual and reproductive health guidelines, maternal mortality/health, Afghanistan, fragile state, reproductive health care services, pregnancy, childbirth and post childbirth complications, SRH strategic framework, applicable SRH approaches, international SRH guidelines, decision making, socio-cultural beliefs, barriers to sexual and reproductive health services / utilisation, SRH pilot study, SRH efficacy. The bibliographies of papers found in the databases were also searched for relevant documents.

2.5. Location of the Study

This research was conducted in two geographical sites (Eastern and Western districts) in Kabul, Afghanistan, each with a diversity of ethnic groups (Pashton, Tajik, Hazara Uzbek, Arab and Noristani). Fieldwork was conducted principally in health facilities (district hospitals and comprehensive health clinics) rather than primarily in homes or community settings as was initially planned, due to the diminishing trust of strangers by Afghans as insecurity levels increased distrust and safety concerns.

The MoPH/Kabul Health Administration Office, due to insecurity and associated limitation of movement, selected 2 health facilities {the Ahmad Shah Baba District Hospital (ASB/DH) and the Bagrami comprehensive Health Clinic (CHC)} in eastern Kabul district for the first three and a half months of my fieldwork. I was required to submit a fieldwork report to the Kabul Administration office of MoPH, after completion of fieldwork in one site in order to obtain official introduction letters for the second set of sites, Dashte Barchi District Hospital (DB/DH) and Pul e Khoshk comprehensive Health Clinic (PKH/ CHC) in the western district of Kabul.

Figure 3. Kabul Districts Map



Available at: http://commons.wikimedia.org/wiki/File:Kabul_districts.png

Bagrami district, on the edge of Kabul city, is a very poor semi-rural setting where people have limited access to the basic determinants of health, in particular safe drinking water, sanitation, education, paved roads, healthy food etc. In comparison with this rural area, the second more urban location (Ahmad Shah Baba Mina/Arzan Qimat) has a good health care facility (DH1) because this district hospital is supported by MSF and people who live near to the DH have good access to basic social determinants of health. The eastern district, Dashte Barchi (DH2) and Pule khoshk (CHC2), are very poor districts in western part of Kabul. The photos (1-8) demonstrate a snapshot of DHs and CHCs locations.



Photo 1. CHC 1, Bagrami



Photo 2. CHC 1, Bagrami CHC Front yard



Photo 3. DH1, Triage section



Photo 4. DH1, Ahmad Shah Baba entrance



Photo 5. DH 2, Dashte Barchi DH



Photo 6. DH 2, Gyne/Obs Ward Dashte Barchi



Photo 7. CHC2, Women near the door of Pule Khoshk



Photo 8. CHC2, Pule Khoshk CHC building

The below Table 1 provides some contextual information about the 4 research sites.

Table 1. Description of Research Sites

No.	Research Site	Location	Estimated Population of each District	Ethnicity	Distance from the City	Health Facility Type	Funds	No of Health Staff
DH 1	Ahmad Shah Baba (ASB)	District 12	350,000	Pashton & Tajik, Uzbek, Arab, Noristani	One hour by Taxi	District Hospital	MoPH-MSF	MoPH 52 MSF 260
CHC 1	Bagrami	District 12	68,287	Pashton/Tajik & Hazara (minority)	45 Minutes by Taxi	Comprehensive Health Clinic	MoPH	MoPH 9
DH 2	Dashte e Barchi (DB)	District 13	700,000	Hazara & Tajik (minority)	45 Minutes by Taxi	District Hospital	MoPH/MSF*	MoPH 41
CHC 2	Pul e Khoshk (PKH)	District 13	3000 households	Hazara	One hour by Taxi	Comprehensive Health Clinic	MoPH	MoPH 11

Source: CSO 2014 and HMIS 2013, AREU 2005

Table 1 highlights the uneven distribution of HSPs in the health facilities as opposed to the population size across the districts. For instance, around 260 health staff works for MSF and 52 for MoPH to respond to the need of growing inhabitants of this district and displaced population from other provinces of Afghanistan. MSF provides health services, but the emphasis is primarily about emergency care within the district hospitals. The MSF mobile team provided RH care to remote areas (e.g. Spina Poza and Pul-e-Charkhi). However their activities restricted due to the insecurity and lack of funding.

In contrast, the density of population in Dashte Barchi DH2 is double that of ASB/DH1, but only has 41 MoPH health service providers, which indicate that they are poorly staffed with less than 20% of the former's health service providers. Moreover, the 2 health facilities in the Eastern districts of Kabul indicate the diversity of ethnic groups who have been displaced from various provinces of Afghanistan. However, a majority of the population in the Western district of Kabul is of Hazara ethnicity.

* In December 2014 MSF started providing 46 bed Gyne/Obs care services in Dashte Barchi District Hospital (MSF 2014)

2.6. Recruitment Criteria and Sample Description

Purposive sampling was used and 450 participants, including pregnant women, women who have newly delivered, household members especially mother-in-law, husband, sister in-law, health service providers, psychosocial counsellors, governmental and non-governmental organisations health staff, human rights activists and religious leaders, were recruited in this research.

Research Participants' Inclusion Criteria Consists Of

- Married, pregnant women and women who have recently given birth.
 - Husbands and other household members
 - Religious leaders
 - Health Service Providers (HSPs) employed within the research sites
 - Psychosocial counsellors
 - Civil society and gender activists
 - Policy makers
 - Governmental and non-governmental senior health staff
- **Research Participants' Exclusion Criteria Consists Of**
 - Non-relevance to the research topic health issues e.g. cardiovascular or kidney problems, diabetes, high cholesterol, pneumonia, TB, Malaria etc.
 - People who are mentally incapacitated
 - People who are members of the Armed Forces
 - Children (See more details in Ethical and Feasibility Issues sub-section)

Study participants were from various parts of Afghanistan, since they were displaced to the districts near the Kabul due to insecurity and joblessness in their provinces. Table 2 below illustrates participants from 23 provinces and 74 districts and sub-districts. Table 3 provides a summary of participants from 23 provinces of Afghanistan.

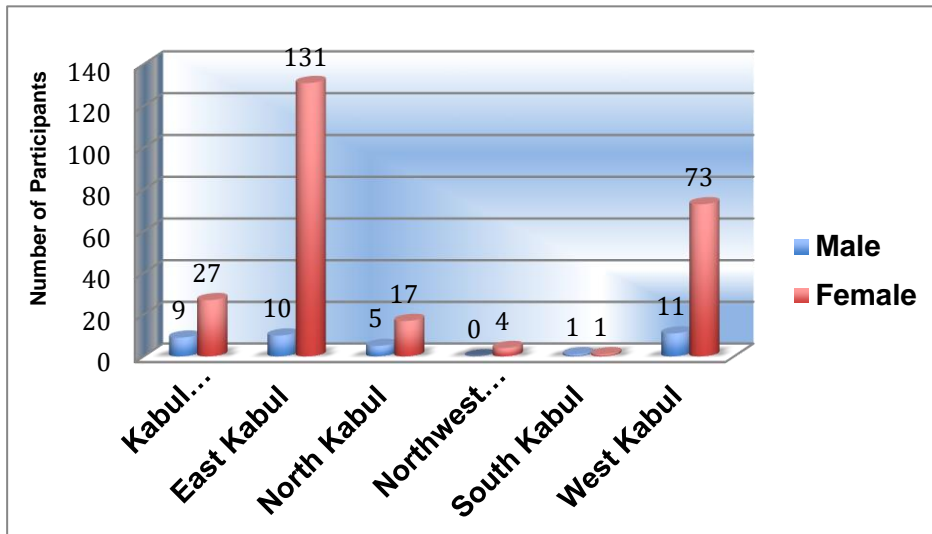
Table 2. Summary of Participants by District, Location, Ethnicity and Gender From Kabul Districts

Participants' by Location, Ethnicity and Gender							
No	Province	Districts	Location	Ethnicity	Male	Female	Total
1	Kabul						
	1	Alokhail	Eastern Kabul	Tajik& Pashton	0	2	2
	2	Arzan Qimat	Eastern Kabul	Tajik& Pashton	1	20	21
	3	Bagrami	Eastern Kabul	Tajik& Pashton	3	18	21
	4	Botkhak	Eastern Kabul	Tajik	1	6	7
	5	Char Qala e Chardi	Western Kabul	Hazara & Tajik	0	3	3
	6	Chehlseton	Western Kabul	Tajik	0	2	2
	7	Dar ul aman	Western Kabul	Tajik	1	3	4
	8	Dashte Barchi	Western Kabul	Hazara & Tajik	2	14	16
	9	Deh Afghanan	Centre Kabul	Tajik	0	1	1
	10	Deh Dana	Western Kabul	Tajik& Hazara	0	2	2
	11	Guldara	Northwest Kabul	Tajik	0	4	4
	12	Hawa Shenasi Maidan	Centre Kabul	Tajik	0	2	2
	13	Hod Khail	Eastern Kabul	Pashton	0	2	2
	14	Hussain Khail	Eastern Kabul	Pashton	0	4	4
	15	Istalif	North Kabul	Tajik	0	2	2
	16	Kamari	Eastern Kabul	Tajik& Pashton	1	9	10
	17	Karte Char	Western Kabul	Tajik& Pashton	2	5	7
	18	Karte now	Eastern Kabul	Tajik& Pashton	0	20	20
	19	Karte Se	Western Kabul	Tajik& Hazara	2	10	12
	20	Khair Khana	North Kabul	Tajik& Pashton	2	8	10
	21	Khoshal Khan Mina	Western Kabul	Tajik& Hazara	1	1	2
	22	Kotal Khair Khana	North Kabul	Uzbek & Tajik	0	3	3
	23	Macrorayan	Centre Kabul	Tajik& Pashton	1	4	5
	24	Mahtab Qala	Western Kabul	Hazara, Tajik & Arab	1	5	6
	25	Musae	South Kabul	Tajik& Pashton	1	1	2
	26	Paghman	North Kabul	Pashton	2	0	2
	27	Pul e Charkhi	Eastern Kabul	Tajik& Pashton	0	12	12
	28	Pul e khoshk	Western Kabul	Hazara & Tajik	1	20	21
	29	Pul e Sokhta	Western Kabul	Hazara	0	2	2
	30	Pul e Sorkh	Western Kabul	Hazara	0	2	2
	31	Qalae Nuhman	Eastern Kabul	Tajik	0	3	3
	32	Qala e Shada	Western Kabul	Hazara & Tajik	1	4	5
	33	Qala e Zaman khan	Centre Kabul	Tajik	0	3	3
	34	Qalae Shanana	Eastern Kabul	Pashton & Tajik	0	7	7
	35	Shah Shahid	Centre Kabul	Tajik	0	2	2
	36	Shamali	North Kabul	Tajik	1	4	5
	37	Shina	Eastern Kabul	Tajik& Pashton	1	13	14
	38	Shiwaki	Eastern Kabul	Tajik	1	3	4
	39	Sorobi	Eastern Kabul	Pashton	0	8	8
	40	Taimani	Centre Kabul	Hazara & Tajik	0	5	5
	41	Tarakhail / Pul charkhi	Centre Kabul	Pashton	0	1	1
	42	Wazir Akbar Khan	Centre Kabul	Tajik, Pashton & Hazara	8	9	17
	43	Zan Abad	Eastern Kabul	Tajik& Pashton	2	4	6
	Sub-Total				36	253	289

Table 3. Summary of Participants by District, Ethnicity and Gender From Provinces of Afghanistan

Participants by Location, Ethnicity and Gender							
No	Provinces	Districts	Location	Ethnicity	Male	Female	Total
2	Badakhshan	Faiz Abad	Northern Afghanistan	Tajik	1	1	2
3	Baghlan		Northern Afghanistan	Pashton & Tajik	0	3	3
4	Bamyan	Kamard	Northern Afghanistan	Hazara	0	4	4
		Panjaw	Northern Afghanistan				
5	Parwan	Charikar	Northern Afghanistan	Tajik & Pashton	0	9	9
		Ghorband	Northern Afghanistan				
6	Ghazni		South East Afghanistan	Hazara	0	5	5
7	Ghor	Kohband	West Afghanistan	Hazara	0	5	5
8	Helmand	Lashkargah	South West Afghanistan	Pashton	0	1	1
9	Herat	Heart	West Afghanistan	Tajik	0	1	1
10	Kandahar	Kandahar	South East Afghanistan	Pashton	0	1	1
11	Kapisa	Tagab	Central Afghanistan	Tajik & Pashton	1	10	11
		Nijrab					
12	Khost	Khost	South East Afghanistan	Pashton	1	11	12
13	Kunar	Assad Abad	North East Afghanistan	Pashton	2	9	11
14	Laghman	Mihtarlam	East Afghanistan	Pashton	2	19	21
15	Logar	Mohammad Agha	Central Afghanistan	Pashton	3	13	16
		Pul e Alam					
		Welayati					
16	Nangarhar	Jalal Abad	East Afghanistan	Pashton & Tajik	4	19	23
		Sorkhroad					
		Khogianai					
		Batikot					
17	Nuristan	Parun	North East Afghanistan	Noristani	0	1	1
18	Tribal Border Area	Tribal Border area	East Afghanistan	Tribal	0	2	2
19	Paktia	Kochi	South East Afghanistan	Pashton	3	10	13
		Gardiz					
		Zazai					
		Koromai					
20	Paktika	Urgun	South East Afghanistan	Pashton	2	1	3
21	Panjshir	Bazarak	North East Afghanistan	Tajik	2	0	2
22	Takhar	Taloqan	North East Afghanistan	Tajik	0	1	1
23	Wardak	Maidan Shahr	Central Afghanistan	Pashton & Hazara	0	9	9
24	International	N/A	N/A	International	2	3	5
	Sub-Total				23	138	161

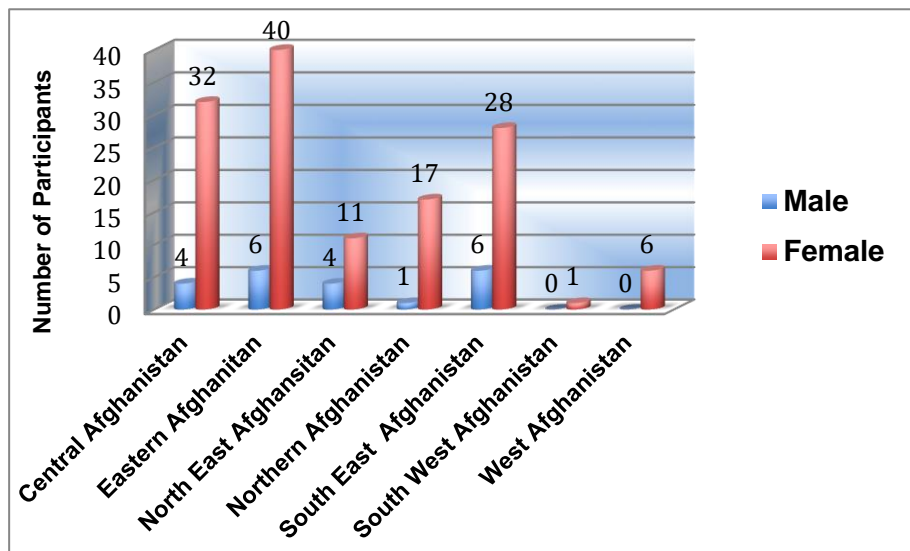
Chart 1. Summary of Settled Participants in Kabul Districts (by Location and Gender)



The above chart 1 reflects on participants' differences in aspects of participation (male and female) from various parts of Kabul districts in the research. Both Table 2 and Chart 1 indicated that 289 participants reside in various districts of Kabul. It is a clear indication that a large proportion of research participants were from the East, West and Centre of Kabul. According to the data, around 141 participants including men and women from various districts of Kabul were included in the research. However a smaller number of participants (84 males and females) from the West district of Kabul are included in the study. People in both the Eastern and Western districts of Kabul have poor economic status and educational backgrounds.

A large proportion of people from various provinces of Afghanistan have been displaced to the Western outskirts of Kabul and they have poor living conditions. Conversely, in the Eastern district of Kabul, a large proportion of people have been repatriated from Iran and Pakistan, and have relatively good access to health facilities.

Chart 2. Summary of Participants in Provincial Afghanistan (by Location and Gender)



This above chart 2 illustrates that around 46 participants were originally from the Eastern part of Afghanistan, including men and women took part in the research. There were 36 participants from the Central provinces and 34 participants were originally from the South-eastern provinces of Afghanistan. The chart 2 and Table 3 illustrate that 161 participants who were mainly from 22 provinces of Afghanistan have been displaced to the districts near the outskirts of Kabul.

Indeed, most of the participants were from the Eastern, central and South-eastern parts of Afghanistan. However, a small proportion of displaced people from very distant and rural areas in West and South-west of Afghanistan were also included in this research.

Taken together the above charts (1&2) show that conducting research in the health facilities provided me with a chance to recruit participants displaced from various parts of Afghanistan and from a variety of ethnicity and language grouping. Understanding the perceptions of recruited participants allowed me to comprehend the breadth and depth of the health needs of various ethnicities and their problems accessing and obtaining health services in both their original place of residence and in the health facilities of my research.

It is important to mention that familiarity with the study locations and the knowledge of local languages and the Afghan context allowed me to firstly be flexible about traveling to sites and carrying out purposive sampling. Due to the nature of the research the recruitment of participants were subject to participants' willingness to speak freely about various health issues according to the development of particular themes within the

data, and the constraints on my research time to collect, transcribe, translate and analyse the data.

To recruit potential participants (health service providers and patients), in public and private health facilities, I first obtained official permission from the Afghan MoPH and directorate of each health facility. Recruitment was through personal approaches at each study site (within health facilities, homes and offices). The recruitment of participants depended partially on the ethnic diversity of the initial parties in each location. A total of 450 participants (comprised of patients 223, family members 72, HSPs 63, governmental staff 31, coordinating organisation employees 17, religious leaders 11, psychosocial counsellors 20, health-promoters 13) were recruited. A break down of research participants into various categories is presented in table 4.

Table 4. Research Participants (by Location and Gender)

Participants	Locations			Male	Female	Total
	Home	Health Facility DH & CHC	Offices			
Pregnant women	9	41	0	0	50	50
Women newly given birth	1	24	0	0	25	25
Patients demanded contraceptives	5	43	3	0	51	51
Women in maternity	1	40	0	0	41	41
Women with other health issues	4	5	0	0	9	9
Women in OPD	0	4	0	0	4	4
Gender based violence cases	5	18	20	0	43	43
Mother-in-law	3	17	0	0	20	20
Husband	10	3	0	13	0	13
Mother	2	9	0	0	11	11
Sister in-law	1	3	0	0	4	4
Daughter	0	7	0	0	7	7
Other household members	4	13	0	3	14	17
Gynaecologists	0	8	3	0	11	11
Doctors (other than Gynaecologists)	0	4	3	6	1	7
Midwives	0	45	0	0	45	45
Psychosocial counsellors	0	0	15	3	12	15
Health promoters	5	8	0	2	11	13
Other Health Staff	0	13		6	7	13
Coordinating organisation (UN, JICA, USAID, AFGA, Health Net TPO, Women for Afghan women etc.	0	0	17	10	7	17
Governmental	0	0		6	12	18
Civil society and gender activists	0	0	5	0	5	5
Religious leaders	0	0	11	11	0	11
Total	50	287	95	60	390	450

The culturally permissible way to contact women in Afghanistan is through personal introductions by other women. At health facilities, I was able to meet with some women who seek SRH services, chat with them in the waiting room, and with their help and if there were willing, to access their households to observe and interview other family

members. A few times the 'snowballing' sampling method was employed through women and their in-laws, and the local health staff (health promoters while providing health education at the community level) visiting women in their homes. There was a risk in 'snowballing', which I could not completely eliminate, that women would refer me to women who had similar stories to their own.

Once I was visiting a participant in her household, other neighbouring women were often also keen to participate in my research and share their SRH service uptake experiences.

While visiting women in their homes, I was accompanied by my research assistant. To take sociocultural beliefs into account and avoid participants' agitation expressing their views regarding SRH issues and services, I interviewed 26 women in their households and my research assistant interviewed 11 male participants. In addition, for the better outcome of data collection, my research assistant and I were jointly conducting FGDs where all participants were men, mainly with religious leaders.

After being introduced to the participants, I shared a copy of the participation information sheet and obtained the consent of participant to take part in the study (See Appendix A). The participant information sheet and consent form was designed in 2 national languages (Dari and Pashto), which was approved by the Afghan Ministry of Public health ethics committee. Due to the low literacy level among the majority of participants (pregnant women, women who have newly delivered, family members, husbands) in the study locations, the participation information and objectives of the study were explained verbally and participants were also verbally informed of anticipated consequences, possible risks and possible benefits of the study. Since a vast majority of participants had had little formal education, only around 40% of participants (MoPH health staff, HSPs, implementing organisation's staff, some patients, religious leaders, psychosocial counsellors, civil activists) signed the consent form and obtained hard copies of the study information sheet. Other participants were verbally informed about the research and their verbal consent was obtained.

Many research participants preferred public places or waiting rooms for free discussion as a natural and comfortable environment to be seen talking with another woman without raising suspicion from the family members.



Photo 9. Women are Standing In front of OPD Section



Photo 10. Women are Waiting to Obtain Visiting Card

2.7. Data Collection

To ensure the collection of comprehensive data and credibility of findings, a combination of multiple methods of data collection under the umbrella of methodological triangulation were used to increase the research credibility (Mitchell 1986, Patton 2002, O'Reilly 2009, Mays & Pope 2000, Tashakkori & Teddlie 2000, Buse & Mays 2012). For instance, the data for the policy analysis combined theoretical considerations with published and unpublished documents (policy and strategy documents, books, brochures), statistical data from HMIS and health facilities (monthly and quarterly reports, patients' records and tally sheets) and secondary source data through literature review, as well as field data from interviews and focus groups. These varied sources provided more unbiased insight into the topic and helped to draw comprehensive conclusions.

Field data collection started late September 2013. Throughout the 8 months of data collection, I usually visited CHCs in the mornings and DHs in the afternoons because CHCs are open from 8:00 a.m. to 12:00 p.m. and therefore I scheduled my data collection, arranging and conducting participant observations and semi-structured interviews in the DHs in the afternoons. To conduct follow-up interviews and observations I sometimes had home visits. In addition, medical documents and records of all four-health facilities were collected and audited.

To gain initial access to the health facilities and to observe the behaviour and practices of HSPs, a written official permission letter from the MoPH was obtained. After receiving the

official letter from the Administrative Kabul Office of Ministry of Public Health to the health facility, I routinely obtained health staffs consent for observing their everyday work and practices. The participant information sheet and consent form (See Appendix A) were given to participants in their preferred national language (either Dari or Pashto). Their signature was requested in the consent form.

I used to make notes from my interviews, and every evening after reaching home, I used to transcribe my daily data and notes. After around 5 months of data collection, I returned back to Durham for almost one and a half months to start writing a progress report, organise the compiled data and check if any information is missing. Returning back to Kabul, I resumed the second phase of my fieldwork by conducting semi-structured interviews and focus group discussions with HSPs, gender activists, religious leaders, coordinating organisations staff, MoPH SRH department senior staff and policy-makers.

To arrange FGDs with the MoPH staff and coordinating and implementing organisations staff, a list of questions were sent to the ministry prior to conducting FGDs. A summary of data collection methods with site types and number of participants is shown in table below.

Table 5. Data Collection Methods and Number of Participants

Method of Data Collection	Male	Female	Total No. of Participants
Health Facility- based Interviews	6	149	155
Coordinating Organisations/ MoPH staff interviews	9	14	23
Home-based Interviews	12	26	38
Focus Group Discussion (MoPH, NGOs, the Afghan Mosques Administration Office)	26	48	74
Life Narratives (DH, CHC, home)	0	9	9
Participants Observations (DH, CHC)	7	124	131
Participants Observations (Office)	0	20	20
Grand Total	60	390	450

Additional research questions were identified during the course of the fieldwork as understanding was gained. To address these, an organised topic guide (See Appendix A) was used as an initial planning tool guiding FGDs and interviews to elicit more detailed and specific responses and recall each important topic (Bryman 2012). This initial guide was supplemented (and/or substituted as appropriate) with questions raised as observational data collection progressed. This mixed-method approach helped in

obtaining in-depth, natural and unbiased person-centred perspectives from diverse Afghan ethnic groups.

2.7.1. Participant Observation

Observation of the women's daily lives, their family dynamics and interactions, health staff service provision and interaction with patient's family members, and other staff participants took place over an extended period of time. I judged how useful each observation was when assessing the maximum time devoted to each participant. For instance, I routinely observed participants at the health facilities' waiting rooms and during uptake and provision of health services. I used to introduce my self and the purpose of my observation to the participants. In addition, I spent around 4 hour a day in the houses of those women and their family members whom agreed to be observed in their household. Extended observations were negotiated with the participants according to their availability, family circumstances and the interest value of themes being played out in each individual's life. I obtained participants' consent prior conducting participant observation.

Since it was difficult to make notes during observations, I used to make notes upon leaving the site or when returning home. Afterwards, I was writing my observational notes in Microsoft Word documents in full detail.

A total of 131 participant observation sessions were conducted in the health facilities and in the households however 17 males and 9 female declined to be observed. Twenty observations conducted in the offices mainly office of Afghanistan Independent Human Rights Commission (AIHRC). These helped me to obtain different views from diverse ethnic groups that would not have been possible in one specific locality. To obtain a reflexive interpretation of participants' perceptions, through understanding social roles, knowledge of local languages and being approachable, I worked to keep a balance between being a stranger and over-rapport (Dewalt & Dewalt 2002, Guest 2013).

At the individual level, I observed family members' behaviour towards pregnant women or women who have recently given birth, and SRH seeking behaviour of selected women and their household members were observed in their homes and health facilities.

At the health service providers (HSPs) level, I benefited from being an 'insider' (an Afghan national medical doctor), which allowed me to establish rapport with the health staff and observe their interaction and behaviour towards patients in a facility-based customary

services practices. I also observed their routine health practices during shifts. I explored their attitudes and behaviour (verbal and non verbal) to identify the potential impact on women's willingness to seek health services. Observing HSPs at any time (I had flexible time to observe any health facility ward or section) allowed me to obtain robust and detailed descriptions of the routine processes of SRH service provision.

2.7.2. Semi-Structured Interviews

These methods allow researchers to obtain considered responses from participants, which allow them to provide explanations of identified behaviours and complex matters. I conducted 215 face-to-face interviews in households and health facilities. During the recruitment of potential participants 26 male and 22 females declined participation in my research.

The participant groups and individuals chosen for interview were decided once observations of pregnant women and health providers in the DHs and CHCs had been conducted. Semi-structured interviews were conducted with women, their household members and HSPs within public and private health facilities. Interviews with each participant varied from 30 to 120 minutes.

While sitting among and observing women in the Outpatients Department (OPD) and inpatients Department (IPD) waiting rooms, it was not difficult to find participants for interview, because women commonly opened the conversation. In other words, women frequently approached me wanting to talk about their longer waiting time and/or personal and health related issues.

It was not always possible to observe and interview the same participants in ANC, PNC, FP and maternity sections. Sometimes after having done the observations, participants were selected based upon their willingness to take part in the research and share their opinion during an interview. I talked to participants who had obvious presenting health problems and participants who did not.

Since I knew of women's multiple health issues from my observations, I made sure to keep a balance of participants who were willing to be interviewed around different sorts of health issues, and women who just wanted to do normal health check-ups or obtain preventive health services.

Semi-structured interviews were advantageous in terms of flexible questions and allowed me to explore the desired topics and different aspects of participants' lives. To explore participants' perceptions in greater detail, some participants were willing to have follow up interviews. Moreover, interviews allowed me to pursue an understanding of important factors that were not otherwise clear. Over a hundred interviews were audio-recorded after providing information about the purpose of interview recordings and seeking written or verbal permission from the interviewee (Dewalt & Dewalt 2002).

2.7.3. Life Narratives

Life narratives method was not part of planned methods of data collection however it happened spontaneously. Over the course of data collection when I interviewed some participants, nine research participants were happy to share their life stories. Of 9 participants, who told their life stories, 8 were recruited either at DHs or CHCs and one participant was recruited at home. These nine participants' life narratives were different from standard interviews because these women shared their life experiences and concerns over their life cycle. These life narratives allowed me to understand the complexity of women's life issues and the impact of various factors on their health and well-being over time. It is horrific that none of these women had approached Human Rights specialists or other women's groups within Afghanistan for help.

Although obtaining participants' life stories was time consuming, my non-judgmental engagement throughout women's discussion in terms of their life stories demonstrated their trust and paved the way to understanding how some participants could interpret their life experiences, beliefs and roles of other individuals in their lives (Moriarty 2011).

2.7.4. Focus Group Discussions (FGDs)

After conducting participant observation and interviews with women and clinical staff, and in order to seek the perception of non-governmental health organisations' staff, MoPH policy-makers, religious leaders, psychosocial counsellors, civil society and gender activists, and to explore the best applicable short and long term approach in Afghan context, I organised focus group discussions.

In the same way, some participants from coordinating organisations themselves asked me to arrange FGDs in MoPH so that they could directly talk to the MoPH/RH senior staff and also be aware of other coordinating organisations' projects and activities. Therefore, a combination of interviews with senior governmental and non-governmental staff and their

discussions and debates in FGDs helped me compare their diverse and sometimes contradictory opinions.

I arranged 19 FGDs in various locations (MoPH, coordinating organisations offices, the Afghan Mosques Administration Office, Human Rights Independent Commission Kabul Office and health facilities). The size of each focus group varied from 4 to 15 participants, 15 FGDs were consisted of mixed gender participants. Two FGDs conducted solely with male religious leaders. Two FGDs with civil and gender-based activists and psychosocial counsellors consisted of only female participants.

A total of 74 participants including senior HSPs at the health facilities, health staff of coordinating non-governmental organisations, religious leaders, gender-based and civil activists and psychosocial counsellors took part in FGDs. During participants' recruitment 14 male and 4 female potential participants declined participating in FGDs. In addition to gaining health system level understanding of sexual and reproductive health issues through discussion, the FGDs helped me to observe the reaction of participants and their attentions towards their roles and responsibilities.

Participants in FGDs seemed to be very keen to be involved in discussion and express their point of view. At the health facilities and MoPH, participants were happy to share their perspectives. Sometimes, due to time limits, they demanded another FGD session in order to further discuss health issues in much more detail. FGDs took a maximum of 2 hours, with the exception of two focus groups in which the participants requested additional discussion time. In both cases the discussions carried on the following day.

Arranging FGDs and gathering participants from different organisations in MoPH/RH office was challenging because of their busy schedule, security concerns and road blockages. Twice some of my FGDs participants did not turn up as planned. However with the support of MoPH/ RHD, I was able to reschedule FGDs sessions.



Photo 11. FGDs in MoPH/ RHD Office

FDGs around the lack of coordination in the health sector and addressing specific issues in the health system and health service provision level helped me highlight the major gaps within the health system, but on the other hand, also unintentionally, often acted as a coordinating mechanism between different layers of staff in organisations. A summary of data collection methods with number of participants and potential recruit declined to participate is shown in table below.

Table 6. Summary of Recruited Participants and Potential Recruit Who Declined to Participate

Method of Data Collection	Participant Recruited		Potential Recruit Declined to Participate	
	Male	Female	Male	Female
Semi-Structured Interviews	27	189	26	22
Participant Observation	7	144	17	9
Life narratives	0	9	0	0
Focus Group Discussion	26	48	14	4
Total	60	390	57	35
Grand Total	450		92	

2.7.5. Medical Documents and Records Review

Over the period of fieldwork, medical documents such as ANC, PNC and maternity tally sheets were reviewed. In addition, monthly activity reports of each district CHCs and hospital's section were audited. After obtaining approval from the MSF health coordinator, I was able to obtain the digitised annual data from the HMIS section of Ahmad Shah Baba district hospital (ASB/DH) in Excel sheets, which was categorised by each section of DH (ANC, PNC/ FP and Maternity). Whereas, patients' records and monthly data from Dashte e Barchi DH and CHCs were only available as hard copies. Since the HMIS offices of health facilities, especially Dashte e Barchi DH, did not allow me to carry hard copies of the monthly report, I took photos of the monthly reports for further review at home. In addition, monthly report of DHs and CHCs were obtained from MoPH/ HMIS department in order to compare and contrast data from health facilities with the official data from the HMIS database. These reviews and audits of health facilities' records and documents were helpful in terms of their contribution to understanding data reliability and the lack thereof. The quantitative data has been utilised in the research in a descriptive way to provide a snap shot of the reporting gaps and errors. Photos 12&13 show paper-based tally sheet and monthly report.



Photo 12. Monthly Report



Photo 13. ANC Tally Sheet.

2.8. Field Data Analysis:

In this mixed method research, observation notes, interviews, FGDs recordings and life narratives were transcribed verbatim into the native languages (Dari & Pashto) and then translated into English language. I coded for themes using thematic analysis in an iterative process to identify the most frequent and important themes (Miles & Huberman 1994, Trochim 2006-07). Using Microsoft software (Excel and Word document) programs sped up organising traceable electronic data and data analysis.

These phases of my research work were challenging because translating the information from two original languages (Dari and Pashto) and transcription at the same time was time consuming. In order to perform these activities I had to concentrate on listening to the recordings in a quiet space, relatively free from any interruption.

I undertook a NVivo training course to manage my data. Although I felt that a smooth and systematic analysis and the management of fundamental collected field data were easier done in Microsoft Office. It was evident to me that the NVivo software did not have the capacity to save my 2-3 hours of interview audio recordings and very long word documents of transcription. In addition, in the on going process of data analysis, I found NVivo software less useful in terms of in-depth understanding and content analysis of data, which would challenge the issues of validity and reliability of emerged themes (Morse 1994, Trochim & Donnelly 2007, Strauss 1987, Miles & Huberman 1994, Udo1997, Welsh 2002).

Instead, using Microsoft Excel, I created numerous index sheets and categorized my interviews with patients and HSPs, FGDs, interviews with governmental and non-governmental staff and gender based violence cases (See appendix B). In each sheet, highlighted labels, descriptive codes and shared themes from the range of participants' transcriptions in the Word document were added to Excel spread sheets. I found it convenient to number and filter my data with the help of Excel function keys.

The emergent themes from the rich and consistent data (See Appendix C) were beyond my expectations. In order to narrow them down and set the over-arching themes I aggregated the sub-themes into high level of themes in a reiterative process (Pope, Ziebland & Mays 2000) until I arrived at four specific themes, which are discussed in chapter seven and eight.

I designed a diagram as an illustrative mechanism to visualize the thematic relationships at the individual and household, community, health service provision and health system levels (See Appendix D). As the diagram shows, there are many interconnected sub-themes. It is not possible to focus in detail on all factors and manifestations. The four high-level themes, communication, knowledge, trust and honour that could result in interpersonal violence, and mental illnesses, are explored in details throughout the findings chapters.

2.9. Ethical and Feasibility Issues

The designed research proposal was submitted to, and approved by, the School of Medicine Pharmacy and Health (SMPH) ethics committee. The SMPH approval letter and all supporting documents were submitted to the Institutional Review Board of Afghan Ministry of Public Health (IRB\MoPH) for the permission to commence the research. The Institutional Review Board of Afghan Ministry of Public Health required some changes to the study locations for the reasons of access and limitation of movement. At the same time I shared my concerns with the Durham University SMPH ethics committee regarding the sensitivity of local individuals towards people who study abroad. The Durham University SMPH ethics committee approved my request to identity as a Kabul medical graduate with a condition that the MoPH /IRB should also approve it. After submission of further research documents to the MoPH/ IRB, I obtained their approval. I shared a copy of MoPH/ IRB approval letter with the Durham University SMPH ethics committee.

These changes, together with the implications of the security situation in Afghanistan and my growing understanding as the project progressed, meant that the project at times developed responsively with the aim of understanding the complex array of factors impinging on women's health seeking behaviour during and after pregnancy, and how these play out in the lives of individual women. I therefore sought and obtained amendments from the initial SMPH & MoPH ethics approval to incorporate the FGDs and to extend the interviews to include participants less immediately connected to the provision of SRH services including the psychosocial counsellors, religious leaders and government officials.

Once I had approval from the IRB I submitted their approval letter to the MoPH Administrative Office of the Kabul region. This office decided to issue two certified letters, with the Ministry logo, introducing me to Ahmad Shah Baba DH and Bagrami CHC. They also invited me to provide them with a summary of data collection report from these two health facilities in order to be able to facilitate access to 2 other health facilities.

The official letters from the Ministry of Public Health to the staff of public and private health facilities introduced me as a Durham University student. However at the local level, due to people's sensitivities towards outsiders and in order to avert any demand for any financial incentives, I was introduced to non-health professionals with a formal letter from the Ministry of Public Health as a medical school graduate who conducts a research around sexual and reproductive health provision and uptake improvement at her own interest and expense.

In the Afghan context, access to the study location, recruitment of participants, obtaining participants' consent and every routine activity for data collection was challenging from a western ethical stance. For instance, one ethical constraint was the limited power of decision-making for some women regarding their choice whether or not to participate in the research study. Even if a woman was willing to participate in the study, rejection by a household member (mainly mother-in-law, sister in-law, husband) could result in non-participation. Similar issues were discussed in Sariola & Simpson's (2011) study of Sri Lanka, which used the term 'Heteronomy' to describe situations when decisions are made by/with others. In other words, in many South Asian countries, including Afghanistan, decision-making is not individualistic. It exists within a family relationship. Considering the ethics of research and to avoid any sensitivity, I used to approach the most powerful household member first to show respect for his/her demand and obtained informed consent from the member of family and woman at the same time (NCB 2003). It also

turned out that many of the interviewees suffered from minor degree of mental health problems. However their abilities to make informed decisions to participate in the study were not compromised by the nature of their relatively less severe mental illnesses (Legacy 2006).

According to the Afghan Civil Law Code (1977) minimum age of marriage for girls is 16 years and the father has the authority to marry his daughter at the age of 15. In the Afghan context, a young married girl is called a woman and considered an adult. As a matter of fact, many wives and mothers in the study would have been excluded as 'children' had I stuck rigidly to the University of Durham Standard Ethics Guidelines, because in a Western context they would have been considered as children (Green & Thorogood 2014 P. 86, Johnson-Hanks 2002). However they were included because, under Afghan civil law and MoPH ethics committee guidelines, they are classified as adults.

Johnson-Hanks (2002) in her paper made a point that growing up or a life cycle event does not happen in a coherent and linear way. There are various key moments in people's lives, which could go in different directions. For instance, marriage or pregnancy completely changes ones identity and how other people see oneself and one's social relations. I had to recognise that some women younger than individuals defined as adults in the UK could make decisions about themselves and their bodies while some older women did not have decision-making power. This was important because according to the Afghanistan National Development Strategy (ANDS 2013) and many other reports (HRW 2009 UNIFEM 2008a & b) fifty-seven percent of marriages in the Afghan context occur before the legal age of marriage. Initially, I struggled with conflicting advice between the University of Durham and MoPH Ethics guidelines and I thought it might be appropriate not to include married women below the age of 18. However up on consulting further with my supervisor and MoPH, I followed the MoPH ethical advice and included these participants in my research.

My positionality as an Afghan 'insider' helped me to access documentary data, participants' homes, health facilities, MoPH and many NGOs employees relatively easily. I also had the ability to observe the politics between diverse actors and understand their non-verbal cues (Merriam 2001, p. 411, Dwyer & Buckle 2009). On the other hand, since various actors recognised me as a researcher (outsider), they were expressing their views free of any fear or threat. At various times they described the issues in a much-detailed way as if I was not familiar with the topic (Walt & Shiffman 2008).

My professional persona might have affected the answers of some participants especially once they knew I am a medical doctor. For instance some participants at the health facilities were complaining about the HSPs behaviour and practices. However, after finding out about my professional persona, they avoided expressing any negative comments. In a similar way, some health service providers' answers about their routine practices were less detailed since they assumed that I was aware of their practices. In order to avoid bias I tried to maintain a relatively neutral persona with all research participants.

To get the conversation going, I often introduced myself as an inexperienced medical school graduate when talking to patients and their families. This usually prevented participants from bringing forward any health issues, seeking my opinion and assistance as a health professional and thinking about me as a health expert. However, ethical issues did arise because participants were aware that I was a medical doctor, and wanted me to be offering medical support.

I had a difficult time deciding when to remain dispassionate as a researcher when I was observing a lack of care or violence: I wanted to step in there as a human-being. During data collection, I observed many such incidents, which challenged my neutrality as a researcher. Sometimes I felt compelled as a human to intervene in an unjust situation and sometimes it was the research participants in the study who expected me to act as a medical professional, not as a researcher. At times, the choices faced were deeply challenging emotionally, ethically and professionally because to separate myself from my ingrained cultural automatic responses and to choose to remain neutral as a researcher compromised my professional commitment. Likewise, as a member of the same country, a national 'insider', to some extent I accepted my role as a witness of violence whereas, as an 'outsider' I found observing various types of violence very disturbing.

The challenges went beyond those mentioned. I had additional questions to address such as how do I safely and appropriately document the violence? Using my mobile phone, I had the facility to video violence. Afghanistan is very poor country yet mobile phone ownership is very high among men. I needed to consider the consequences for the women. If I had been observed photographing or filming the violence both the immediate consequences and the consequences after I reported my data. I did not have permission to video violence even though I could have asked for it.

On the one hand, the research ethics, to some extent, were really constraining and diminished my role as human-being. On the other hand, in an era where data might be accessible through social media, the ethics of research provide a level of privacy and protection for people who really need to be protected. I decided not to risk adding to the burden and violence Afghan women face. This meant not filming. Sometimes it also meant not responding to circumstances: at other times, it meant intervening. Often it was difficult to know which was the better choice. The ethical codes and statements of the British Social Research Association (BSA), the American Anthropological Association (AAA), the Association of Social Anthropologists (ASA) of the UK and the Commonwealth and Nuffield Council of Bioethics (NCB) do not provide clear guidelines about how to resolve unexpected ethical issues in the low-income fragile states, and note that it can be appropriate to adopt non-standard ethical approaches in certain contexts (BSA 2002, Green & Thorogood 2014 P.88, ASA 1999, NCB 2003).

During observation and interviews, some participants felt threatened by their family members they knew that they were being observed and worried that anything they said or did might be shared with their family members, especially husband or mother-in-law. Given the sensitivity of the topic, special care was made to ensure privacy and confidentiality, and the well-being of participants was given the utmost priority. In order for the women to feel safe, I allowed them to decide the location of the interview within and outside the health facility. Very often (paradoxically from Western perspectives) for many women safety meant being interviewed within a public setting such as the hospital waiting room, where it is normal for women to be seen talking to other women. In other words, from the Western perspectives, it might not seem confidential or private but, because waiting rooms would be a safe place where women normally talk to women, ensuring safety meant doing the opposite to what I would do in the West.

Sometimes, my gender affected my data collection, especially while obtaining information from male participants. Since Afghanistan is a male-dominated society, some participants negatively judged my personality and appearance, especially while talking to a male participants. In order to preclude such condition, my research assistant accompanied me during FGDs especially when conducted with male participants (e.g. religious leaders). However, being a female researcher was an advantage and essential (Green & Thorogood 2014 p.88) for effective communication with women who might not be able to share their SRH issues with the opposite gender.

Moreover, the interviews and discussions were conducted in a voluntary, anonymous and neutral way to avoid any adverse impact on the core values and beliefs of the participants. Compiling data (field notes, audio records, photos) after I obtained consent (written or verbal) from each participant away from the possibility of being overseen was often a part of this.

The primary compiled data is stored in my personal password-protected external hard disk and is protected from unauthorized access to the data. A password-protected copy of original audio recordings was secured on a CD, which was stored at my home. Only the principal investigators and project supervisors had access to the English language data for analysis. Further, a password-protected external hard disk, CD of the audio-recordings and signed consent forms are deposited in a locked cabinet at the office of the School of Medicine, Pharmacy and Health for the required amount of time after the final publish of research (possibly 5 years as per my ethics approval).

2.10. Reflections on the Application of ‘Framework of Thinking Model’

Although initially, I planned a qualitative ethnographic research, participant observations combined with semi-structured interviews were my method of data collection. I wanted to understand the individual actors’ dynamics within one specific community however a significant change in my research site due to insecurity and inaccessibility reasons occurred.

I had to change ‘Multi-Layered Explanatory’ model to the ‘Broader Framework of Thinking’ model. The iterative process by which the framework was initially identified and developed in conjunction with the early stages of my fieldwork to guide my understanding of gaps in the data set and direct choices I made further data collection. The application of the ‘Broader Framework of Thinking’ model in practice helped me conceiving of a more dynamic relationship between the elements within it. The elements of this model were much interrelated than immediately obvious. As I began to conduct policy analysis and explored social factors I realised I need a deeper knowledge of each element in an iterative process.

Part of the apparent elements of model, there were more aspects to be known because each element feeds the other element. For instance, to understand the role of ‘Actors’, my first research objective about ‘how policy makers view their roles and responsibilities for

implementing SRH' was changed and I began to understand how policy-makers go about their roles, assuming and operationalizing their responsibilities to implement SRH?

Since there is evident relationship of this overarching model to data collection methods, I ended up going back and forth the linkage over time, which means as opposed to planned 60 research participants I ended up recruiting 450 participants and applied various methods of data collection.

The above information reflects the unexpected issues particularly insecurity and diverse social issues change the research design, methods of data collection and number of participants. Further information can be observed in the project protocol incorporating all amendment approved by the ethics committee in Appendix (F).

Chapter Three

3. The Historical Development of The Global Political Agenda Around Sexual and Reproductive Health Rights

Sexual and reproductive health, which refers to women's health over their reproductive life-cycle (pregnancy/antenatal, childbirth and post delivery/natal) has been identified by Amnesty International as an important human rights issue (Rio+20, 2012, Ryutaro 2015, Santhya & Jejeebhoy 2015, Sen & Govender 2014).

This chapter reviews the growing universal significance of sexual and reproductive health rights (SRHRs), policies and the global political agenda over the past 29 years. In addition, it is critical to understand what the SRHRs agenda means for fragile states like Afghanistan, drawing upon lessons learnt from other countries where pertinent.

This chapter begins by exploring the historical perspectives of WHO and other organisations in advocating SRHRs improvement. It will also address initiations for SRH system improvement in the low-income countries, especially fragile states. This chapter concludes with an outline of how universal access to SRHRs evolved through years, even though it was developed in Western countries what resistance, and explores they faced, which elements were contested and why they were contentious?

3.1. Historical Perspectives on Sexual and Reproductive Health

Over the past 60 years, many international and governmental entities undertook initiatives to address universal health issues (Scheel 2011, Travis 2004). However, SRH and rights had not particularly been addressed in the global health agenda in the preceding decades and it took a longer period of time for them to be recognised in the global health agenda as a significant universal health issue.

In 1950s and 1960s, there was conspicuous focus on the issue of population dynamics and disease treatment. However the SRH related issues were overlooked (Travis 2004, Brolan & Hill 2014, Newman 2014). Indeed, in the 1950s, global health systems

were curative oriented and any specific health issues such as SRH were not adopted in the political agenda.

In the 1960s, interconnectedness between poverty and numerous health issues was acknowledged. Emphases were made on the social determinants of health, such as sustainable social and economic development, jobs and increase in labour income, in order to decrease the prevalence of diseases and poverty (Herrmann 2014). Subsequently, the Alma-Ata declaration in 1978 underlined the health system-strengthening plan through primary health care services. It emphasised multi-sectoral commitments to achieve sustainable economic and social goals, which could help promote human-rights through healthier nations (Scheel 2011, WHO-Alma Ata 1987, Travis 2004).

The Alma-Ata declaration demonstrated a bottom up approach and it was a shift from curative to preventative health care. The World Health Organisation (WHO) enunciated the Alma-Ata declaration as the fundamental framework for civil societies' capacity building and health system-strengthening. Likewise, people's awareness of their rights to uptake higher quality health care services was considered crucial (Ibid).

To outline specific strategies and interventions for the reduction of maternal death ratio and pregnancy and childbirth complications, a call for actions was issued at the Nairobi conference (Mahler 1987) as the Safe Motherhood Initiatives (SMI) and was introduced at the national and international levels (Maine & Field 1999). The WHO and other UN agencies sought international commitments and funded SMI awareness meetings with policy makers from around 90 countries during 1987-1994 (UN 1995).

Consequently, the confluence of two policy trends has shaped maternal health care services (Sen 2014). First, reforms to health system policies and funding following a 'Neoliberal' approach (WHO 2015b), which means addressing higher quality health service provision and social determinants of health such as access to safe water and sanitation, employment and nutrition and poverty reduction (WHO 2008). Second, after many years of debate and negotiations, universal access to and SRHRs without any discrimination and violence was addressed. It became Sustainable Development Goal (SDG 5) and was first recognised and included in the agenda of the Vienna 1993 conference on human-rights, followed by the Cairo 1994 International Conference on Population and Development (ICPD) (UNHR 1993, UN 1996, UNICPD 1994, Sen 2014). However, it has been argued that the adoption of a 'Neoliberal' approach or focus on SRH system-strengthening, does not cover all elements of SRHRs, because SRHRs

also presupposes legislation against abortion; young age marriage and female genital mutilation (FGM), which are not included.

It has been suggested that as part of health system-strengthening, male involvement and understanding of religious beliefs, social acceptability and cultural practices can be added to political agendas in order to improve gender equality and access to SRH services (UNHR 1993, UNICPD 1994). These initiatives were further backed up in the 1995 Beijing 'platform for action' program (UNWoman1995, Haslegrave 2013, Newman 2014, Sen 2014). This was a great achievement for the SRHRs activists because policy-makers and funders formerly considered general health issues but did not recognize the universal significance of SRHRs.

During the Cairo International Conference on Population and Development ICPD and Beijing conferences (UNICPD 1994, UNWoman1995), momentous SRHR issues were debated. For instance, topics around sexual rights, improving policies and guidelines for higher quality SRH service uptake and provision, emergency obstetric services, access to safe abortion, sexual education and SRH system-strengthening were part of the discussions.

Subsequent to the ICPD (1994) and the Fourth World Conference on Women (1995) many policies emphasised the significance of male involvement as a key aspect for reduction of unintended pregnancy, STIs, interpersonal violence, reduction of maternal mortality and morbidity and, more importantly, access to SRH services. Overlooking men's SRH awareness and service needs that are similar to those of women, contribute to wider gaps in SRH service uptake and improvement (Kumar 2007, Sonfield 2004, UN/WCWPA 1995).

Sexual and Reproductive Health and Rights advocates faced many objections and challenges because sexual rights did not have clarity in terms of sexuality, sexual health services uptake and education, safe abortion, female genital mutilation (FGM) and gender violence (Sen 2014, Haslegrave 2013, Newman 2014, Sen & Mukherjee 2014, Sen & Govender 2014).

Indeed, one of the most sensitive issues that created controversy was SRH education. Later the language was corrected by stressing the importance of the parental guidance during the life cycle of adolescents, although issues related to parents and in particular men's SRH awareness remained blurred. Some groups reasoned that none of the governments would consider women's rights and provide broader access to safe abortion.

Sexual and reproductive health and rights advocates ensured that the SRHR issues were incorporated into the conference agenda. However, the outcomes of their efforts were not satisfactory, and the SRHRs topic still remains controversial (Sen & Mukherjee 2014, Haslegrave 2013, Newman 2014, Sen 2014).

Parallel to the debates and discourse around SRH, the International Human Rights Organisation acknowledged health as universal rights in their convention and wanted SRHRs to be incorporated into the global political agenda. It has been mandated that health policies and programs should promote women's access to health care services and not hinder their access by promoting the need for authorization of a family member, specially in the contexts where women's access to health care services often requires a male family members' permission (WHO 2007a, Asbjorn 2011, Sen 2014). The 12th article of the convention emphasises the elimination of all forms of violence and discrimination against women (CEDAW) calls for access to higher quality and free health care services during pregnancy, childbirth and post childbirth, family planning services, and proper nutrition during pregnancy and post childbirth (Germain 2015, Sen 2014).

Under the umbrella of the CEDAW convention, it is suggested that some social customs and practices should be changed, such as young age forced marriage, multi-pregnancies, lack of birth spacing, and no ANC and PNC visits, which all increase women vulnerability to death and health complications (Ibid).

However, the implementation of some articles of the conventions appear challenging because decision-making in terms of SRH service uptake in many countries is not usually individualistic. For instance in Uzbekistan, similar to other countries in the region, including Afghanistan, reproduction is core pillar of family relations. A newly wedded girl is expected to get pregnant even if she is very young or too immature to have a baby (Hamzaeva 2008, WCLRF, FFF&AWLC, 2008, WCLRF, 2009). Thus, the social expectations and economic constraints associated with living in a joint family would make it challenging for women to make individualistic choices about education, marriage and access to reproductive health services.

It is important to mention that over 90% or 185 members of the United Nations, including Afghanistan, agreed to comply with CEDAW convention since 2003. The right to health has been remarkably recognised as a human-rights (WHO 2007a). These countries included human-rights in their legislative systems to promote gender equality and their

equal access to SRH services under the benchmark of a 'Human Rights-based' approach (Haslegrave 2013, Newman 2014, Sen 2014, Asbjorn 2011).

In many countries, particularly low-income and conflict-affected countries, girls' and women's health, well-being, opportunities, social involvement and status are overlooked and their rights are undervalued. For instance, Percival (2014) argues that despite the acceptance of health as a human-rights issue, gender equity has not been incorporated into all health systems. For instance, Afghanistan ratified the CEDAW convention in 2003 but is failing to fulfil the commitment to implement the convention, particularly in terms of women's rights to access SRH services, education and gender equality (Barr 2013, UN 2015, WCLRF and HBS 2008, WCLRF 2013, UN/CEDAW 2011).

A study by the Women and Children's Legal Research Foundation (WCLRF 2008) called Afghan women's health status 'miserable'. Since sociocultural, political, economic and biological issues are linked to the diminished reproductive rights of women to access health services over their life cycle, this report demonstrates that the Afghan government and legislative system have not substantially ensured women's rights to access health care services, particularly during pregnancy and childbirth.

In summary, improving access to SRH services has risen up the policy agenda as more health organisations become involved in improving SRH service uptake and education. Although there are still sensitivities around SRH policies, and some issues, mainly related to sexual rights (sexual health services uptake and education, safe abortion etc.), are still not necessarily incorporated into the health systems of many countries.

There is a tension between what is advocated as the best SRHR practice globally and the policies to which all countries should be signing up to, and the extent to which they are willing and/ or able to be involved. This ongoing resistance to emerging policies is what was left out of the SDGs agreement.

3.2. The Millennium Development Goals and Sexual and Reproductive Health and Rights (MDGs and SRHRs)

Following the acknowledgement of the SRH and rights' broad concept in the Cairo International Conference on Population and Development (ICPD) in 1994 and the Beijing 1995 'platform for action for equality development and peace' program (Haslegrave 2013, Newman 2014, Reddy & Sen 2013, Sen 2014, UNFPA 1994a, UNWomen 1995), in the year 2000, the United Nations' 191 members agreed on a declaration of eight Millennium Development Goals (MDGs) and agreed to pursue and accomplish these goals by 2015 (Travis 2004, WHO 2007b, Yamin & Boulangerb 2013, Sen 2014).

The eight MDGs comprised reduction of poverty and hunger (MDG1), provision of primary education and eradication of illiteracy (MDG2), upholding gender equity and empowerment (MDG3), reduction of child death (MDG4), maternal health improvement by reduction in maternal death ratio (MDG5), fighting against prevalence of HIV/AIDS, Malaria and other diseases (MDG6), preserving clean environment (MDG7), and fostering global development partnership (MDG8) (UN MDGs 2013, 2014 & 2015).

Some scholars argue that many aspects of SRHRs sat apart from the MDGs agenda. The MDGs demonstrate that only non-sensitive issues are picked and some significant issues of women's health rights are excluded. Prevention of sexual violence and safe abortion faced resistance from some conservative groups and therefore such issues were not included in the MDGs (Haslegrave 2013, Newman 2014, Reddy & Sen 2013, Sen 2014).

On the one hand, a number of civil society organisations shared their concerns about overlooking SRHR, gender-based violence and young age forced marriage in the MDGs (Reddy & Sen 2013, Sen 2014 and Yamin & Boulangerb 2013). On the other hand, many of the organisations involved acknowledged the significant impact of MDGs specifically on countries where governments set targets and put efforts into achieving these goals (WHO 2007a, Reddy & Sen 2013).

The MDG5, which consisted of two targets (A and B) were regarded as a 'Person-centred' approach. However the focus was only made on maternal health improvements and there was no mention of SRHRs (Yamin & Boulanger 2013, Reddy & Sen 2013, Falconer 2010).

Millennium Development Goal (5A) aimed to reduce death by three folds until the end of 2015. Although maternal death is only one of many SRH elements other SRH elements such as family planning, safe abortion, higher quality sexual and reproductive health service uptake, SRH education, STIs and STDs were not included in the MDG 5 A (Hill 2013).

It took further two years for the UN General Assembly to recognize the need for MDG5 target B. In 2006 UNFPA urged the UN General Assembly to include target B to MDG5 and the target B indicators were finally added in the year 2007 (Yamin & Boulangerb 2013). Target B comprised of universal access to reproductive health such as; increase in the contraceptive prevalence rate, unmet needs for family planning and four ANC visits. However, the extended elements of SRH and rights such as abortion, marital age and sexuality education, remained too sensitive and a constricted issue to be fully acknowledged by policy-makers and funders (Hill 2013, Brolan 2014, Sen 2014).

Since MDG5 only addressed reductions to maternal death ratio and did not fully cover SRHRs, some argued that the funding system and projects shifted to specific, selective and vertical programs, which detracted from health system-strengthening and multi sectoral approaches (WHO 2007b, Scheel & Engjom 2011, Reddy & Sen 2013). It is debated in some papers that in order to support countries for understanding and complying the commitments for women's health and well-being, the health organisations and funders either focused on a few cost-effective vertical interventions to target some specific diseases with higher prevalence and maternal death ratio statistics or a horizontal intervention to scaling-up balanced, curative and preventative primary health care services (Scheel & Engjom 2011, Reddy & Sen 2013).

World leaders and WHO members came together to review the MDGs achievements and challenges and identify applicable and sustainable development goals (SDG)* for post-2015 global health (Kendall & Langer 2015, WHO 2014a). The base lines for assessing the MDGs progress were the year 1990 and the deadline for achieving these 8 Millennium Development Goals were 2015. The figures and facts were taken from various health indicators, which were compiled as part of Multiple Indicator Cluster Survey (MICS) and Demographic and Health Survey (DHS) (UN MDGs 2014, Haslegrave 2013).

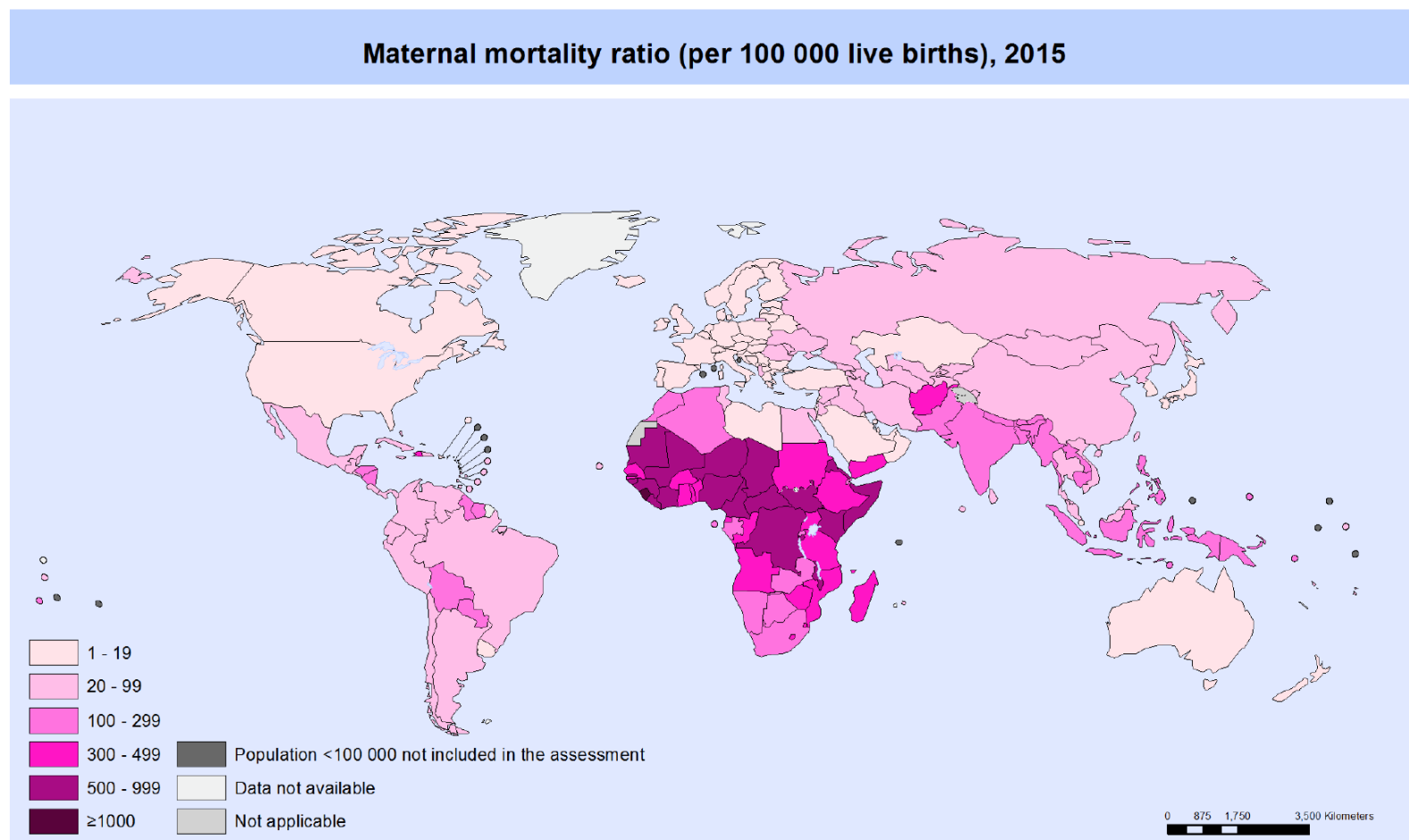
* SDGs will be discussed in detail in the next sub-section

According to the United Nations MDGs reports (2014, 2015 and Zeid 2015), some improvement in MDG5 has been observed. For instance, since 1990, there has been a 45% decline in the maternal mortality ratio globally, which means the lifetime risk of a woman dying in childbirth has declined from 1 in 73 women to 1 in 180 women. However, in fragile states the estimated lifetime risks for maternal deaths are 1 in 54 women (Zeid 2015). Global access to skilled birth attendants increased from 59% in 1990 to 71% in 2014 and access to contraceptives among women aged 15-49 increased from 55% in 1990 to 64% in 2015. However, the reports highlighted that 52% of women had access to at least 4 ANC visits in 2014 in developing countries. In sub Saharan Africa for instance, 49% of women and 36% of women in Southern Asia including Afghanistan had at least four ANC visits in 2014. The UN MDGs reports show that these development goals served as a stimulus and initiated to provide specific measures against global health issues, particularly in low in middle-income countries (UN/MDGs 2014 & 2015, Zeid 2015).

However, some papers reviewed the health outcomes and stated that equal and effective health services have not been provided sufficiently to people who need them (Scheel & Engjom 2011). For instance, maternal and child mortality and morbidity in low and middle-income countries failed to decline considerably due to the lack of proper health care services during pregnancy, childbirth and post childbirth, lack of knowledge related to SRH, lack of access and availability of skilled health service providers and other resources (WHO 2014b, Kendall & Langer 2015, UNICEF,WHO,WB, UN Pop Div. 2013).

According to the 'Trends in Maternal Mortality' report, from 1990 to 2015, the global estimation of MMR was categorised in four sections (WHO, UNICEF, UNFPA, WB and the UN Pop Div. 2015). First there were 9 countries that reduced MMR to at least 75% between 1990-2015 and were classified as 'on Track' countries, 63 countries were recognised as 'making progress' category, whereas, 21 countries were classified for 'insufficient progress' and 26 countries were categorised as making 'no progress' towards reduction of MMR.

Figure 4. Maternal Mortality Ratio (2015)



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
 Map Production: Health Statistics and Information Systems (HSI)
 World Health Organization

 **World Health Organization**
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The burden of maternal death in low and middle-income countries is also underlined as a serious challenge because, despite the efforts of governments and NGOs, every day hundreds of women die from various pregnancy or childbirth complications (UN MDGs 2013, 2014, 2015 and Zeid 2015). For instance, the United Nations MDGs reports and WHO's trend of MMR report indicates that around 300,000 women died in 2013 due to preventable pregnancy and childbirth complications. Where ratios remain high it is frequently because women do not have access to health services or a skilled health provider. In addition, some papers conclude that absent social determinants of health such as insecurity and fragility, poverty, lack of proper food and clean drinking water and population dynamics, also hinder higher quality SRH service provision and uptake (UN MDGs 2013-15, Zeid 2015).

Furthermore, evidence demonstrates challenges in terms of SRH service management due to the dearth of sustainable project funding and programs, shortage of health resources and lack of timely and accessible SRH services. These are the underlying factors to achieving MDGs 5 in many countries, particularly in low and middle-income countries (Scheel & Engjom 2011).

A number of organisations including, WHO, WB, UNFPA, UNICEF and UNDP provide an estimated regional maternal mortality ratio between 1990-2015. It is only an estimate due to the scarcity and underreporting of comprehensive systems for civil registration and vital data. These organisations confirm that the actual figures could be more than those that have been estimated (WHO, UNICEF, UNFPA, WB and the UN Pop Div.2015). In other words, in many papers it is confirmed that as a result of poor reporting systems due to the lack of civil registration systems for births, marriages and deaths, the MDGs outcome, relies on statistical estimates (Byass & Graham 2011, Yamin & Boulanger 2013). In Tanzania for instance, the strategic plan enhances the reduction of maternal mortality ratio based on their HMIS (Health Management Information System) reports from district hospitals and households surveys. The report demonstrates many gaps in the reporting and estimation of statistical data (Yamin & Boulanger 2013).

Considering the challenges towards SRH, in 2012 the Rio+20 conference added a section on health and population growth outcomes to the document 'The future we want'. This

was a positive stimulus to discuss the interconnectedness of population dynamics with SRHRs at the post-2015 conference (Newman 2014, UNFPA 2012). However, the key debates in the UN Summit on Sustainable Development Goals in Rio+20 demonstrate that more attention is paid to economic growth and sustainable development, than improving SRHRs services (Yamin & Boulanger 2013).

The active engagement of the SRHR advocates to discuss other determinants of health, such as the poor education, population dynamics, fragile states, insecurity and poverty that hinder proper SRH service uptake and provision, could encourage advocates of other sustainable development goals to understand the significant interconnectedness of SRHR with the other goals, and to undertake SRHRs programs, STIs/RTIs and adolescent reproductive health education along with family planning (UNFPA 2012, Reddy & Sen 2012, Newman & Fisher 2014, Ryutaro 2015). Lessons suggest that SRHRs based on quality, equality and accountability could improve SRHR policies and programs (Sen 2014). Thus, identifying the correlation between these goals paved the way for the inclusion of SRHRs urgencies in the post-2015 conference framework.

Thus far, I have reviewed the historical perspectives of organisations and the universal emergent significance of SRHR, policies and the global political agenda over the last 23 years. In addition, I have discussed the interconnectedness of many social determinants of health such as insecurity and fragility, poverty and population dynamics with SRH service uptake. In the next sub-section I continue exploring the global efforts and resistance faced over SRH improvement in low and middle-income countries, particularly fragile or conflict-affected states.

3.3. MDGs Outcome In Fragile or Conflict-affected States

Fragile states are countries with weak institutions, which are prone to violence and conflict. They commonly become dependent on donating international development communities, are usually at risk of instability and often poor in terms of governance, policy and development outcomes. They also have increased levels of corruption associated with a lack of transparency and accountability (Harttgen & Klasen 2010). According to DFID and WB global monitoring reports in 2007, forty-two countries were classified as fragile states, including Afghanistan, Myanmar, Uzbekistan, Tajikistan, Kyrgyz Republic,

Indonesia and many African countries. Apart from these countries, Pakistan and Iraq are also defined as fragile states, despite having significant resources as, their resource-management and development have remained challenging (Ryutaro 2015, Harttgen & Klasen 2010, WB 2009, WB 2007, DFID 2005, CIFP 2006,).

Around 99% of the maternal deaths and morbidity cases there were reported occurred in low resource and fragile states that lagged behind others in achieving MDGs (Harttgen & Klasen 2010, Ryutaro 2015, Hill 2013, Syed 2006). Despite the efforts of global, governments and aid agencies and the MDG5, there remains a need to reduce the maternal mortality ratio (MMR) in an era of accessible, affordable and sustainable SRH care (Creanga & Gillespie 2011, WHO 2007b, Ryutaro 2015, Snow 2015, SDS Network 2013, Sternberg & Hubley J. 2004). For instance, in 2 articles, Chandy (2011 & 2013) argues that in the year 2005, 20% of population in fragile states was living with poverty. However the proportion of poverty in 2015, according to the World Bank's defined fragile states, reached 51% which means that half a billion of people in fragile states face severe poverty (WB 2015).

Lack of health resources is another challenge in fragile states, which are failing to achieve MDGs particularly MDG 5. For instance, the results of a study in Burundi and Northern Uganda indicated that conflict had a major influence on SRH service uptake among people. This effect is magnified due to health service providers' migration and displacements (Chi 2015). In addition to the shortage of health service providers, a lack of medical supplies, sociocultural limitations to the access of SRH services, patient abuse at health facilities, poor health system management and mis-coordination among governmental and non-governmental organisations also contribute to poor SRH service uptake (Ryutaro 2015).

It has been acknowledged by United Nation's members that the Alma Ata 1978 declaration and MDGs still continue to have a significant impact on the identification of gaps and formulation of the post-2015 sustainable development goals. Likewise, based on the context, socio-cultural acceptability and women's health needs (Ryutaro 2015, Chandy & Gertz 2011, Chandy 2013), the Abu-Dhabi Declaration (2015) underscored the 'Every Women, Every Child' global strategy and stressed policy reforms and the implementation of interventions for SRHR improvement. Under this

declaration, more emphasis was put on supporting SRH system-strengthening and higher quality health care service provision for women through their life cycle in fragile states (Zeid 2015). This declaration calls on the global community to develop strategies that uphold reproductive, maternal and newborn, child and adolescents (RMNCA) health and rights over their life course in the settings affected by conflict and crisis.

As discussed in the preceding sub-section, discrepancies in the data around the maternal death ratio from a large proportion of countries indicated that, due to insecurity and fragility, less than 40% of countries have a fully functioning civil registration system (registration of birth, deaths and causes of deaths), which is crucial for precise and actual MMR census (Herrmann 2014, Byass & Graham 2011, Mathers 2005, UN 2014&2015, Yamin & Boulangerb 2013). For instance, out of the 115 countries that shared death registration data with WHO, around 40 countries including Afghanistan, did not share data around the number of births and deaths (Mathers 2005).

Indeed, a lack of data from these 40 countries could be explained by poor surveillance and reporting systems. For instance, Afghanistan has the second highest child mortality ratio (99/1000 live births) in the world, which means that 1 in 10 children dies under the age of five (AMS 2010, UNAMA, 2013, WHO/AFG 2012). This estimated ratio could presumably be higher, since only 35% of children are officially registered at birth, and more than two thirds of home-based childbirths remain unregistered (NRVA 2011-12). Therefore the deaths of mothers and newborn babies are not being registered at health facilities (Rasooly 2014) and the records are likely to be incomplete and inaccurate.

3.4. What Next?

In the year 2005, the United Nations started observing issues of SRHRs closely (Haslegrave 2013). The SRH framework was included in the UN sponsored sustainable development agendas (HLP 2013-14, Brolan 2014, Kismödi 2014). Some key players from multi-lateral agencies during post-2015 SDGs working groups meetings argued that it would be better to discuss SRH without mentioning the sensitive word of 'rights'. Some believed that WHO was promoting universal health coverage in a way might leave SRH and rights aside. However, some others believed that more attention should be paid to the area of population health and well-being improvement over their life cycle (Brolan 2014, Hill 2014, Boerma 2014).

Although SRHRs was included in the ICPD conference for post-2015 agenda, yet more emphasis has been made on the reduction of a high fertility rate (women with above three children), which is believed to have significant impact on economic growth, and poverty reduction. Nonetheless, the issue of population growth itself was controversial in terms of fertility, because the fertility rate, which was elevated in only 49 low and middle-income countries, had actually declined in other countries (UNFPA 2012, Boerma 2014, Greene 2005).

Ultimately, after years of negotiation in 2005, 2012-2014 (HLP 2013b, Brolan 2013, Kismödi 2014), the Sustainable Development Goals discussed in the United Nation's summit in 2015, built on lessons learnt from the MDGs achievements and failures, which contested interconnected global issues. Unlike the 10 SDGs proposed in 2013 and 2014, the final number of SDGs declared in 2015 was 17 SDGs (and 169 operationalize targets), which should to be achieved by 2030 (SDG 2015, Germain 2015).

Access to higher quality SRH services, reduction of MMR to less than 70/100,000 live births and reduction in communicable and non-communicable diseases are included as targets under Goal 3. Universal access to SRH and reproductive rights without any discrimination and violence is included as a target under the Goal 5 separately. It was vital that at every stage of the negotiations actors (global and national) were challenged and the interconnectedness of SRH and rights and sustainable development was advocated, so that SRHRs comes to be viewed as a core SDG (UN 2015, Gupta & Gupta 2016).

According to the post-2015 SDGs working groups, the issue of SRH and rights awareness through legislative and comprehensive health systems needs to be enforced in low and middle-income countries particularly in fragile and conflict-affected settings (Gupta & Gupta 2016). Some papers posit that in order to achieve universal access to higher quality SRHRs, including family planning, information and education and elimination of child or forced marriage, the integration and implementation of these two parallel SDGs is essential (Gupta & Gupta 2016, Germain 2015).

In summary, there have been very complex and long processes for the SRHR to be acknowledged and included in the political agenda. Over 29 years of global efforts will pay off and the interconnected SDGs will be achieved if all governments, particularly in conflict-affected countries comply, and have a commitment to identify potential factors that have a direct and indirect impact on SRHRs services and the achievement of the 2030 targets.

Chapter Four

4. The Context of Sexual Reproductive Health Policy in Afghanistan and Its Implementation

In this section, the contextual factors (Leichter 1979) including geography, development levels and an overview of the existing health system that affect SRH policy are explored. This chapter draws upon published literature supplemented with interviews excerpts and internal MoPH official documents obtained during my data collection.

4.1. Afghanistan Background Overview

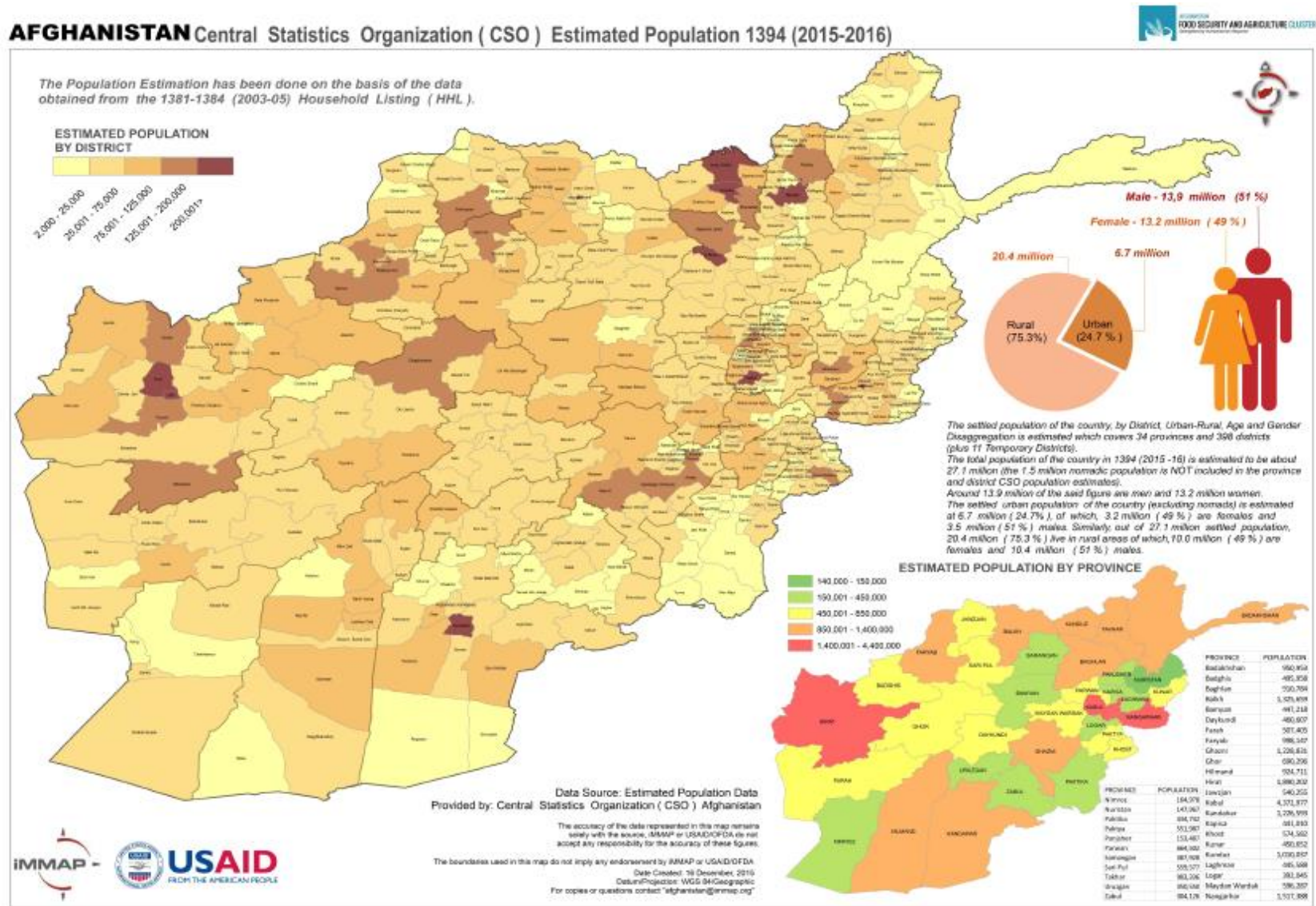
Afghanistan is situated in the heart of Asia. It is a landlocked country, which is surrounded by Tajikistan, Uzbekistan, Turkmenistan, Iran, Pakistan and China. Thirty-four provinces and 394 districts administratively separate Afghanistan with an estimated (settled and nomadic) population of 26.5 million (CSO 2015). The bulk of the country is sparsely populated. As showed in the map (Figure 5) there is very few urban cities in Afghanistan with population densities approaching those of western urban norms.

More than thirty years of difference, in life expectancy at birth, between the affluent nations and Afghans (49.3 years) has been highlighted in the Afghan Mortality Survey report (2010). However in the UNDP/AFG recent report (2015) estimated 60.4 years life expectancy at birth.

According to the Central Statistics Organisations (CSO) survey report, the advent of basic living standards or social determinants of health for all Afghans i.e clean drinking water, sanitation and hygiene could significantly improve population health. However, only 57% of the total Afghan population has access to safe drinking water and 28.5% of people have access to improved sanitation facilities and adequate living standards (UNDP/AFG 2015, UNICEF 2016, AMICS 2011). As a matter of the fact, due to the poor sanitation and living standards, and shortage of clean drinking water, people suffer from various air/vector/waterborne diseases, e.g. Typhoid, Hepatitis, Leishmaniasis, TB and Malaria

(SC/ UK 2012, NFP/MoPH 2006-9). The prevalence of malaria and tuberculosis (TB) remain a major challenge to public health. The WHO report (2015a) highlights that over 27% population in 2014 was threatened by high prevalence of malaria mainly in the Southeastern provinces of Afghanistan. In another report WHO/AFG (2012) estimated over 10,500 deaths per year from TB. An alarming proportion of official TB cases (66%) are detected among Afghan women who are more vulnerable to the disease due to the lack of regular access to the health facilities for treatment. It is likely that TB cases are under-reported because many patients have limited access to appropriate TB treatment facilities.

Figure 5. Afghanistan Population Map (CSO 2015-16)



Despite the Afghanistan National Development Strategy's (ANDS 2008–2013) goals for the reduction of poverty, Afghanistan remains at the bottom of 170 countries, with a poverty rate of 49.9% (UNDP/HDI 2015). In the regional context, Afghanistan ranks the second poorest country in Asia after Bangladesh (MoE & WB 2010). To be clear, half of Afghan population live in multidimensional poverty: their daily income is less than 2 US Dollars and they cannot afford to pay for basic living expenses and obtain access to proper food and non-food needs (health, education and minimum level of income). The UNDP 'Human Development Index' report (2015) underlines how deprivation in health (19.2%), education (45.6%) and living standards (35.2%) contributes to overall poverty in Afghanistan.

In spite of the efforts of many national and international organisations, over 60% of the Afghan territory is too inaccessible for food and crop aid, and 28% of the Afghan population is food-insecure. According to the Afghan Ministry of Agriculture, the United Nations World Food Program and a UNDP report (MoAIL 2013, FAO 2013, UNDP 2011), one third of the Afghan population suffer from hunger and famine due to insecurity and drought, and the rest of the population remains on the borderline of food shortages. Indeed, around 54% of preschool children (6-59 months) suffer from stunted growth and this proportion is classified as the highest level of chronic malnutrition across the globe (HMIS 2013). To gain a better understanding of the context for such a poor country, the next subsection provides extended information about Afghanistan's security, economic and political conditions and the impact of these on poverty and the social determinants of health.

4.2. Security, Economic and Socio-Political Aspects

Political power (CSO & UNICEF 2012) can play a significant role in a context where there is a source of oil, arms factories, drugs or geopolitical location (Fassin & Pandolfi 2010, p269) and Afghanistan, is one of the countries with a significant geopolitical location (Emran 2013). Over 30 years of continuing civil war, disorder, foreign invasion and militant religious insurgency has left Afghanistan economically and politically dependent on international aid. In spite of humanitarian aid flow and achievements such as the formation of a parliament and Afghan Army, and expansion of primary education

and basic health, there have not been substantial improvements in poverty reduction, security, stability, bureaucracy and corruption reduction and basic infrastructure such as access to higher quality health care services, proper housing and jobs (Waldman 2008, Howard 2014).

It is widely known that the Afghan conflict has paved the way for humanitarian interventions. Indeed, Afghanistan is one of the main recipients of international funds. Ten main donors, including the United States, pledged 62 billion US Dollars for the reconstruction of Afghanistan during the period 2002-2013. However, only 26.7 billion US Dollars were disbursed until 2009, 77% of this with little or no involvement by the Afghan government (Poole 2011). This report of global humanitarian assistance indicates that out of 26.7 billion US Dollars of international aid, 84.6% was spent on foreign military operations, 5.6% on multilateral peacekeeping and 9.4% on security related aid (ibid). Likewise, Waldman's analytical report (2008) demonstrates that a vast majority of aid is spent on military assistance, particularly in the Southern part of Afghanistan. Waldman argues that 40% of aid (2001-2008) was returned back to donor countries via the recruitment of donor agencies' expatriates and advisors of their own countries with high salaries, contractor fees and security costs.

Similar concern was shared in the WB report (2012) that 'most international spending 'on' Afghanistan is not spent 'in' Afghanistan'. Some studies demonstrate that much of the aid has been driven by donor priorities and political interest, instead of considering Afghans' needs and demands (Baird 2010, Glyn & Abby 2012). In fact, according to Waldman (2008) technical assistance for governmental staff's capacity building, and allocation of more funds to the insecure provinces, though desperately needed, were not demand-driven or national priorities. He recommends that donor agencies should allocate funds for the reduction of poverty, economic growth, gender equality, health improvement, expansion of primary education and infrastructure. Such programs, however, require accurate population data for the entire country.

In Chapter 3, the significance of civil registration for the management of fertility rate and population growth, and the collection of reliable statistics in terms of death and birth, was discussed in detail. Despite the aid flow, the civil registration system in Afghanistan has not evolved over the years. Afghans only have paper based national identity documents

and births, deaths, divorces and marriages are often not officially registered (Refworld 2012, VRS 2013).

Evidence shows that as a consequence of civil war, violence is deeply ingrained in Afghan society, and the interlacing of violence across all sectors impacts on all aspects of women's life and their social exclusion (ICG 2011, WCLRF & HBS 2008). Violence, which is widespread within the country, draws on social, political and economic power imbalances. Such imbalances play-out in the daily life of people, who suffer from poverty, gender and health inequalities (Glyn 2012, Galtung 1969 Pp. 167-191). Issues related to gender inequality in Afghanistan were highlighted in the UNDP 'Human Development Index' report (2014-15). Afghanistan in gender inequalities is ranked 152 amongst 155 countries. Likewise, Afghanistan has a 31.4% loss in the human development index, which ranks the country as 171 amongst 188 countries (UNDP 2015).

It is evident that the years of conflict, migration and inadequate health services increased drug dependency in Afghan society (Nawa 2011 p118). Afghanistan accounts for 90% of opium cultivation, drug production, and trafficking in the world (Todd 2007, UNODC 2013, Fassin & Pandolfi 2010). Although this impacts on Afghans as well as in the countries to which illicit opium is exported, in Afghan culture and Islamic religion drug use is formally forbidden. There are thought to be around 1.9 to 2.4 million adult drug users (12.6% of population) in Afghanistan (UNODC 2015) of which women comprise over one hundred and twenty thousand of the addicts mainly in rural households (CJTF 2012). Research highlights that the reasons behind women's addiction are poverty, lack of social support, lack of access to health care facilities and the cost of medication, which results in the usage of opium as a cheap and available pain killer and sedative (Nawa 2011, UNODC 2010, Perky 2007).

From a different perspective, research conducted by Nawa (2011 p.118) highlights poverty and the negative impact of opium cultivation and trade on the lives of Afghan women and girls. This reveals that many Afghan farmers borrow money from drug traffickers to invest in cultivating opium. Those farmers who fail to repay the debt to drug traffickers give their daughters or young women as compensation. Women do not have the right to fight against this and have to leave their families to pay the debt by slavery or prostitution.

Instability and a lack of effective governance damage the peace, stability development and wellbeing of the whole Afghan nation but these problems are exacerbated by linguistic and ethnic differences and conflict between Afghan communities (Walter 2008, Lalzad 2008, Akbar 1976, Tapper 1991). Not only does linguistic discrimination between two official national language speakers (Pashto and Dari) remain common but ethnic conflict between numerous tribal groups, (Pashton, Tajik, Uzbek, Turkmen, Hazara, Nuristan, Aimaq, Baloch and others) has both produced and sustained conflict, due to a lack of unified support for all ethnic groups by various Afghan governments (Walter 2008, Shahrani 2012, Barnett 2002, Ghubar 2012).

4.3. Education

It was highlighted in the preceding section that insecurity and instability have a profound impact on Afghan social, health and education infrastructure. Insecurity exerts a huge influence on people's knowledge seeking behaviour. Although, education is a step towards future prosperity, the Afghans' total literacy rate is only 47% with a huge gender gap and disparity between males at 61.9% and females at 32.1% (NRVA 2011-2012). The MoE/ EFA (2015) report demonstrates that over the last decade, there have been some improvements in education and women's social involvement particularly in urban areas and the proportion of school enrolment has increased from one to 9 million between 2001-2015. However this report indicates that only 37% of girls were enrolled in the year 2015.

According to the ministry of Education, there are 420 registered private schools in Kabul and a total of 830 private schools in the whole Afghanistan, which strengthens the education system. However the privatisation of the education sector strengthens the social barriers between rich and underprivileged people (Shahrani 2012, Ghubar 2012).

The education sector is also supported by international finance. In 2015, the Global Partnership for Education (GPE) approved an indicative grant allocation of 100 million US Dollars to support Afghanistan's education sector between 2016-2018 (MoE/EFA 2015). In spite of this support, the Afghan education sector faces many challenges. According to Ministry of Education (MoE), 42% of school age-children do not have access to education while over 500 schools are without shelter or walls, safe drinking water and toilet facilities.

Exacerbation of insecurity in 10 provinces of Afghanistan in the past two years (2014-15) led to the closure of around 453 schools (MoE 2015b).

Further, despite free and publicly provided primary, secondary and higher education and books (school students only pay for their uniform and transport), many students remain unable to access school. Due to poverty around 45-50% of school age boys work and do not go to schools (NRVA 2011-2012, MoE 2010).

There is a major literacy gap between males and females. Since, socio-cultural beliefs predominantly restrict girls' access to education, there are no female enrolments in 10-12 grades in over 200 schools in Afghanistan (MoE 2015b, MoE/EFA 2015). The following map (Figure 6) indicates the adult female literacy levels in all the provinces.

Figure 6. Adult Female Literacy Rate by Province



Source: Afghanistan National Education for All (EFA) Review Report, 2015

The yellow colour on the map shows that less than 10% of females are literate across the 18 provinces of Afghanistan (MoE 2015b). In some provinces, the movement of girls and women's outside the house in order to acquire education is prohibited due to insecurity and sociocultural beliefs (NRVA 2007-8, UNAMA 2013). According to Bashir (2013) insecurity in many provinces of Afghanistan causes the closure of schools and health facilities, as well as, the cultural taboos and social stigmas that limit women and girls movement and access to education and health care services. Therefore, they miss the chance of obtaining an education and meeting social needs. Their lower literacy levels are considered to be one of the dominant constraints to the improvement of the socioeconomic and health systems of the country (Amowitz 2002, Zarin 2011).

Moreover, the 'Afghan Mortality Survey' report (2010 p.53) shows that there is a positive link between education and marriage. Those girls who continued to study at least up to secondary or tertiary levels delayed marriage by 5 years more than those with no education. Studies by WCLRF (2008&9) demonstrate that many girls lose the chance of gaining a good education when they are forced to marry before reaching puberty.

4.4. Family Relationship, Gender Inequalities and Socio-Cultural Beliefs

Afghan families build the basis of society. Afghans prefer bigger families, particularly in rural areas. According to the NRVA survey (2011-12) the average size of an Afghan family is 7-8 individuals.

Referring to Islamic teachings, it is explicitly stated in the Holy Quran (Surah 'AlBaqarah') "*Men and women have equal rights towards each other.*" It is also mentioned that Islam emphasises the rights of boys and girls to acquire an education and select his/her future partner or marry by mutual consent, and the avoidance of any kind of gender discrimination (AFGA 2012). However, in some Islamic contexts like Afghanistan, women and girls are not properly treated or given the authority of decision-making about their life (UN/CEDAW 2011, WCLRF 2009).

Many reports highlight the issue of young age marriage in Afghanistan. The reports reveal that 57% of girls are married before the age of 16 (Smith 2009, UNIFEM 2008a&b, HRW

2009 and ANDS 2013). In many rural areas, gender inequalities arise when Afghan girls maintain their 'family honour' within society and get married at a young age instead of attending school (NRVA 2007-8, Lalzad 2008). Although Afghan legislation and Islamic rules prohibit child marriage, early age arranged marriage is socially and traditionally accepted in many Afghan families (Smith 2009, UNIFEM 2008a&b, Lalzad 2008 Pp.192-3), to such an extent the average age of marriage amongst girls in rural areas is 15 and 16 in urban localities (SCF UK 2012). Moreover, although, Islamic rules give a girl the right to select her life partner (AFGA 2012 P.67), forced young age marriage is practiced in many Afghan families. The UNFEM and AIHRC report (2008) indicates that in 70-80% of marriages one of the individuals in the couple did not agree to marriage but were not in a position to either reject the unwanted partner or divorce (UN/CEDAW 2011, AFGA 2012). (Divorce is a taboo in the Afghan context, and many people, especially women, avoid appearing in judicial institutions in order not to go against family and community values).

Several studies have identified health as one of the significant qualities for a desirable bride or wife in Afghan ethnic groups. In some Pashton ethnic groups, for instance, if women seek out health care services, their in-laws and relatives question her health status hence her worth as a woman (Bashir 2013, Rasekh 1998, WCLRF 2009). This leads young women to avoid discussing health concerns and/or seeking medical help. This is significant given that due to reproductive system immaturity, young women suffer disproportionately from the risk of pregnancy and childbirth complications (WHO 2012b, Blood 2001, Hadi 2012, SCF/UK 2012, WCLRF 2008). On the one hand, early age marriage and pregnancy in the first years of marriage in the Afghan context contributes to maternal health issues. On the other hand, young women miss out on the chance of gaining an education and they remain unaware of reproductive health services (Farmer 2004, NRVA 2011-12).

Other factors such as insecurity, economic hurdles, and parents' literacy level contribute to young age marriage and a lack of decision-making power for reproduction, as well as, high levels of gender discrimination, domestic violence (Janes & Chuluundroj 2004, Wall 1998, UN 2006, WCLRF & HBS 2008 & 2009) and cultural factors around women's status and freedom of movement (PHR 2002). For instance, the United Nations' report (2006) on

violence against women in Afghanistan demonstrated that young age forced marriage is the foremost reason behind interpersonal violence. Similarly a report by the Afghanistan Human Rights Commission (AIHRC 2015b) indicates over 3000 registered cases of personal/domestic violence against women. This is a society where violence is accepted and mostly not reported.

In Afghanistan, interpersonal violence (physical, verbal, sexual, psychological, behavioural) is common against women and takes place within the household and at the community level (AIHRC 2015b&c, Smith 2009, Rana 2007). Verbal or behavioural violence can refer to more than the commonly understood meaning of the term. For example, calling women by various abusive names and a man's refusal to accompany a woman to a health facility or perhaps deterring his wife from seeking health care services from a male health service provider can be considered 'violence' (UNAMA 2013, Amowitz 2002, WHO 2012a, WHO 2012c, Hegarty 2014) because women lose their identity and the chance of SRH service uptake, which is their rights.

In some Afghan ethnic groups, actual interpersonal violence is considered the norm (WCLRF 2009). It is believed in some Afghan families that household violence and physical beating mentally prepare women for marriage at a young age, and to tolerate their in-laws' oppression (Bashir 2013). This belief undermines the implementation of laws to bring about the elimination of violence against women, as these laws and policies have been dismissed by a number of conservative lawmakers (UNAMA 2013).

Another issue is the custom of polygamy, which is encouraged in various ethnic groups, since it is legally and religiously legitimate for a man to have up to four wives if he can afford to fulfil their equal needs (Blood 2001, Bashir 2013). Sometimes unease can occur within the extended family environment due to male supremacy or when female family members compete for power. For instance, verbal, physical and psychological violence can arise between mothers-in-law and daughters-in-law or co-wives due to the labour division and control of household resources. Indeed, co-wives compete for their husband and mother-in-law's attention and love by getting pregnant (WCLRF 2006 &2009, WCLRF &HBS 2008).

Although, the power of the mother-in-law is noted by Tapper (1991, p212), Blood (2001), Rahmani and Brekke (2013), the specific roles of the mother-in-law and other women in the household have not previously been identified in relation to health and health seeking behaviours in detail. The details of how these factors affect women health and their ability to access to health facilities are reported in Chapter 7.

It is undeniable that a preference for sons is common in various Afghan ethnic groups (WCLRF 2009). In many Afghan families, especially Pashtons, women who have given birth to sons are more valued in the household (Bashir 2013, Tapper 1991). The son of a family usually receives more attention and resources are channeled into his education and future life because he carries on the family heritage and supports his parents during tribal disputes (Bashir 2013, Blood 2001).

In a study of 800 parents by WCLRF (2009), 69% of them preferred sons to girls. These parents gave many reasons for son preferences. For instance, 44% reasoned that girls are strangers and they will serve another family, 41% said that girls are no use, and around 14% mentioned that girls could cause pain and dishonour to the family. Around 80% of women indicated that their husbands value boys over girls and husbands threatened 7% of women because they gave birth to a girl. Over 54.5% women noticed that giving birth to girl threatens them with a loss of value within both the marriage and the household, which increases their husband's desire to remarry. Over 7% of women faced physical and verbal violence for giving birth to a girl (WCLRF 2009).

Moreover, in some Afghan families, women who give birth to girls do not receive any support, respect and proper feeding from their families. Some women with their baby girls are not welcomed and treated badly (WCLRF 2009). According to the 'Safe Motherhood Initiatives' (SMI) program in Afghanistan (UNICEF & MoPH 2000, WB 2013a), pregnant women should receive social and family support during pregnancy and childbirth. However, men in some Afghan rural contexts have been reported to avoid supporting women during and after childbirth (HMIS 2012, Costello 2006).

The UNDP gender inequality index (2014-15) indicated that over 70% of gender inequality in achieving reproductive health, empowerment and labour market exist in Afghanistan. It argue that women lack confidence in accessing health care services due to the

combination of a need for a male family member to escort them to health facilities, their poor literacy levels, low socioeconomic status (Blood 2001, HMIS 2012, Costello 2006) and health inequality. Thus, in-depth understanding of such aspects can help identify gender roles, women's social and household status, interpersonal violence and human rights violations.

4.5. Health Services in Afghanistan

The Afghan health system reformed and improved between 1980-90. However civil war during the Mujahidin regime (1992-1996) and Taliban era (1996-2001) devastated the whole infrastructures including health systems (Dupree 2011, Haub 2009). Effectively, there was not a health system in operation during the Taliban era (Newbrander 2014). After the fall of the Taliban and the establishment of the Transitional Islamic Republic Government of Afghanistan, the first National Health Strategy and Policy (2002) was developed with the financial and technical support of many international organisations (MoPH 2005).

The Afghan Ministry of Public Health (MoPH) endeavoured to provide primary health care and to reform the national health system. Its main steps towards fundamental reform of the Afghan health system were the establishment of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) in 2005. Basic Package of Health Service protocols cover seven elements and main components of health services. Priority is given to some significant health issues, including maternal and newborn health, immunisation, public nutrition, communicable disease treatment, mental health, disability and physical rehabilitation services and the regular supply of essential drugs.

Inadequate infrastructure, limited resources and the weak capacity of the health sector in the post-conflict or fragile states has made many governments consider short-term solutions and rely on contracting out health service provision to non-governmental organisations (Howard 2014). In fact, the system of contracting-out has become highly popular in the Afghan health system (Bayard 2008). Although some MoPH seniors support it some other officials at the ministry are concerned about the lack of follow-up and accountability for implementations and outcomes. For instance, some NGOs might reduce the cost of services by overlooking some

SRH services in their eagerness to win contracts. Such phenomenon is common in post-conflict countries like Afghanistan where close monitoring and evaluation of project implementation are not properly done (ibid).

To measure and evaluate the BPHS outcome, MoPH applied a quantitative Balanced Score Card (BSC) approach. The BSC report in 2006 indicates that 80% of HSPs conduct proper physical examinations and take a full patient history (BSC 2006). Four provinces including Kabul are in the upper benchmark indicator for providing proper counselling to patients. However, the information is only restricted to numbers, and in-depth information related to HSPs activities, assessments and patients' perspectives of services remain untold (Howard 2014, Peters 2007). A study by Rahmani and Brekke (2013) in Kabul and Ghazni provinces indicated that many HSPs were unaware of reproductive health guidelines and protocols. Additionally, the application of professional standards was lacking in their practices. Thus, details of health service providers' perspectives and observation of their routine practices will be examined in Chapter 7.

To increase access to basic health services in 34 provinces of Afghanistan, the BPHS was contracted out to many smaller NGOs with the technical support of larger donors i.e. United States Agency for International Development (USAID,), World Bank (WB), European Commission (EC), Canadian International Development Agency (CIDA), Global Alliance for Vaccine and Immunisation- Health System Strengthening (GAVI-HSS), Japan International Cooperation Agency (JICA), Global Fund (GF), UNFPA, WHO and UNICEF. These larger donor organisations play a significant role in implementation of BPHS in the following ways:

- USAID, supports projects for increasing access to Basic Package of Health Service (BPHS), Essential Hospital services (EHS), training of female health service providers (HSPs) including midwives, improvement of community based health services and health facilities constructions.
- GAVI-HSS targets health service delivery barriers in the health system. It helps to improve Immunisation and maternal health service outcomes and reduction of child and maternal mortality and morbidity
- JICA strengthens the structural National Tuberculosis Control Program (NTP) and provides capacity building training to the reproductive HSPs.
- GF funds go towards the prevention of HIV, TB and Malaria

{Source: MoPH/ HMIS department (2014)}

There are many types of health facilities provided by BPHS

1. Health Post: basic health services are provided by CHWs (Community Health Workers) in the communities. One male and one female CHW usually provide health services to 1000-1500 community members or 100-150 families. Community Health Workers provide support for birth preparedness, normal home-based childbirth, ANC and PNC (Antenatal and Postnatal Care), treatment of malaria, diarrhea and respiratory infections and referral.

2. Health Sub Centre: Functions as a bridge to connect Health Posts with other health facilities. It aims to cover people's health needs in remote vicinities who have not had any access to other health facilities. Many Health Posts with the financial support of World Bank, European Commission (EC) and the Global Alliance established. Each Health Post provides health facilities to 3000-7000 people within maximum 2 hours of walking distance. Most health services, which are provided by BHC and CHC, are also provided in Health Sub Centers.

3. Mobile Health Teams: health services are offered in remote vicinities by the mobile health teams to strengthen Health Post services and increase patients' access to health services.

4. Basic Health Centre: provides all health services for less than 15000-30,000 out patients. The services are as follows: ANC, PNC, childbirth, contraceptive methods, diagnosis and treatment of infectious and communicable diseases, childcare and immunisation. The staff for BHC consists of one nurse, one midwife and two vaccinators. Physician can replace a nurse if required.

5. Comprehensive Health Clinic: Provides health services to 30,000-60,000 populations with health service provision including ANC, PNC, normal and complicated childbirth, diagnosis and treatment of infectious diseases, immunisation, childcare and physiotherapy for people with disabilities. The number of health workers is increased in CHC. One male and one female doctor and nurses, one midwife either male or

female, psychosocial counsellor, lab and pharmacy technicians and a driver if they have an ambulance.

6. District Hospital: More complicated health issues are referred to the DHs. Each DH covers 100,000-300,000 patients. Various health services are provided in DHs for instance, surgeries, x-rays, EmOC (emergency obstetric care), male and female sterilisations, psychosocial counselling, and lab and pharmacy facilities. Health providers including doctors (female obstetricians/gynecologists; a surgeon, an anesthetist, and a pediatrician) a doctor as focal point for mental health, and psychosocial counsellors/supervisors; midwives; laboratory and x-ray technicians; a pharmacist; a dentist and dental technician; and two physiotherapist (male and female).

These Functional or active health facilities implement the BPHS in three levels:

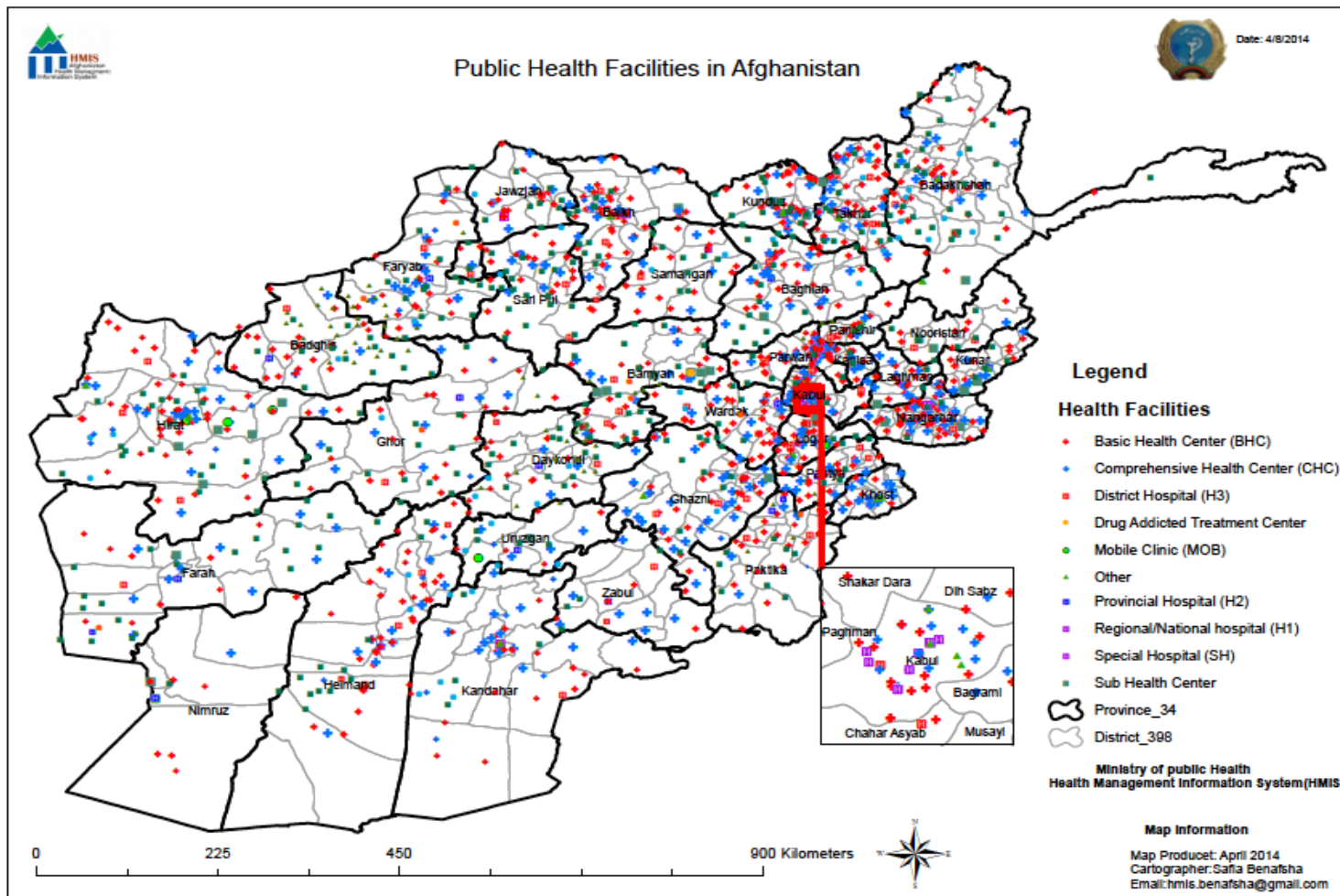
- Primary Health Care Services: {Health Post (HP), Health Sub-centre (HSC), and Basic Health Centre (BHC), Mobile Health Team (MHT) and Comprehensive Health Centre (CHC)}
- Secondary Health Care Services at district level: {Comprehensive Health Centre and District Hospital (DH)}
- Tertiary Health Care Services: {Provincial Hospital (PH), Regional Hospital (RH) and National Specialty Hospital (NSH)}

The tertiary health care services have not been expanded due to a lack of donor interest. Although hospitals' services are less cost-effective, many health services are provided in hospitals.

In spite of being dependent on international funds, the Afghan health sector has made some progress with health indicators, health system rebuilding and the expansion of health facilities, which provide better access for patients to health services (Dalil 2014, Rasooly 2014, Baird 2010, Waldman & Newbrander 2014). For instance, according to HMIS (Health Management Information System) reports 2014-15, the number of active health facilities has increased over 15 years (from 496 in 2002 to 13672 in 2015). Figure 7 depicts the dispersed public health facilities across Afghanistan's provinces by health

facility type, which are inadequately distributed in various provinces. It also suggests that Kabul in particular is densely provided with health facilities. However figures provided elsewhere in this chapter and throughout the dissertation demonstrates that even these are inadequate for the populations' needs, either in terms of the number of health facilities or the number of health staff within them.

Figure 7. Health facilities (BHC, CHC, DH, MOB, SHC, PH, RH and other)



Source: MoPH/ HMIS 2014

The public health sector cannot respond adequately to the high demand for health care services. Therefore the private sector plays a significant role in health service provision. However, there is a huge disparity in provision of proper and higher quality basic health services in urban and rural areas (NRVA 2011/2012).

As mentioned in the 'Security, Economic and Political Aspect' (Chapter 4, section 2), the disparity of funding, project objectives and implementation by non-governmental organisations impact on both health system and health service provision levels. A large number of health officials believe that all issues are linked to political interests (MoPH/RHD 2014). The interview with the MoPH reproductive health director revealed that various health projects are influenced by donor agencies' short-term objectives and the need to gain rapid results (MoPH/RHD 2014).

Furthermore, she said, there is a lack of coordination at the interdepartmental, inter-ministries and aid agencies levels. For instance, each department of the ministry follows specific objectives without informing or coordinating with other departments. In addition, she addressed the issue of ineffective capacity building funded training projects. For instance USAID provides training to the community health workers (CHWs). However CHWs do not put the knowledge into practice. This is because the training materials are in English and even if it is translated into Dari and Pashto languages, the meaning is lost. Even though CHWs carry the training materials around with them they have no profound knowledge of the main concepts.

Knowledge exchange gaps and the disintegration of interdepartmental accountabilities lead to poor monitoring & evaluation of the reporting system. Some interview data with reproductive health departments addressed the absence of follow up or evaluation of the trainings outcomes. They stated that although many international organisations fund training projects, there is limited or no evaluation of their training outcomes. For instance, IMC (International Medical Corps) provided Gender-Based Violence (GBV) training to the HSPs. However after asking the training officer (177) about monitoring and evaluation he replied,

“Actually monitoring and follow-up procedure is not one of our project objectives.”

This indicates that although the MoPH staff is aware of the importance of monitoring and evaluation (M&E) and the gaps in the RH sector, they actually do not take any effective actions to accurately assess the training outcomes. In addition, implementing organisations only follow their project objectives and do not evaluate their work outcomes. Thus, this leads to unreliable data for decision-making and accurate assessment of the SRH service uptake.

It is equally important to note that within the health sector the MoPH and aid agencies have claimed that many international policies, strategies and guidelines have been adapted. Much of the expected health improvements of people from these strategies however remain on paper. For instance, there has been no substantial improvement in the trend for immunisation and prevention of communicable diseases, especially in remote vicinities (HMIS 2013, NMLCP 2008-2009).

4.6. Sexual and Reproductive Health Service Provision and Uptake in Afghanistan

Although, Afghanistan has a slow progress during the past three decades of civil war in terms of reproductive health system improvement (Acerra 2009), this country is still considered one of the 39 countries 'making progress' towards the reduction of estimated MMR to 50%. In other words, one estimate states that maternal mortality ratio declined from 1600/100,000 live births to 327/100,000 live births over 15 years (WHO, UNICEF, UNFPA, WB and the UN Pop Div 2015, Rasooly 2014).

Many papers and the 'Afghan Mortality Survey' (AMS 2010, Dalil 2014, World Bank 2015) demonstrate that there have been consistent and substantial improvements in the reproductive health sector. For instance, since 2002 the number of safer pregnancies and deliveries in rural areas has increased from 8% to 19% (Jhpiego 2011). Furthermore, around 20,000 community health workers mostly women were trained and enrolled in several parts of the country.

Although, the evidence shows that Afghanistan still has one of the highest maternal mortality ratios in the world (UNFPA 2003a, WHO, UNICEF, UNFPA, WB and the UN Pop Div 2015). For instance, the 'Afghan Multiple Cluster Survey' (AMICS 2010-11) noted that

in rural areas only 25% of childbirth occurs at the health facilities, and the rest of home-based childbirth occurs with the support of traditional birth attendants (TBAs), family members, relatives or no one. In urban areas, it is reported that in 2015, 51% of women had institutional childbirth and 49% of women still had home-based childbirth (HMIS 2015). Access to Skilled Birth Attendants (SBAs) in 11 out of the 34 provinces of Afghanistan is lower than 10%. As a result Afghanistan remains the worst place in the world for childbirth (WHO/AFG 2012, UNICEF & CDC 2002, HNN 2010 p.12, Mayhew 2008).

The HMIS annual report (2015) indicates key factors that impact on the increased ratio of maternal mortality and morbidity (MMM) including poverty, gender inequality, some sociocultural restrictions, poor access to health facilities and inadequate SRH service uptake. These factors could also result in haemorrhage, pregnancy-induced high blood pressure (eclampsia and pre-eclampsia), infections and obstructed labour. More recently, malaria, tuberculosis, sexually transmitted infections (STIs), hepatitis, HIV/AIDS and drug addiction have also been identified as causes of MMM in Afghanistan (Harttgen & Klasen 2010, UN 2015). Table 7 compares Afghanistan with other regional countries in terms of MMR, proportion of ANC coverage and total fertility rate.

Table 7. MMR, ANC % and TFR by Countries

Countries	Maternal mortality ratio/ 100,000 Live Births	ANC Coverage %	Total Fertility Rate
Afghanistan	400	47.9	4.9
Tajikistan	65	88.8	3.8
Pakistan	170	60.9	3.2
Bangladesh	170	54.6	2.2
Bhutan	120	97.3	2.2
India	190	74.2	2.5
Maldives	31	99.1	2.3
Iran	23	98.3	1.85
Sri-Lanka	29	99.4	2.3

Source: WHO, UNICEF, UNFPA, WB and the United Nations Population Division 2015, the WB data 2014.
Available at: <http://data.worldbank.org/indicator/SP.DYN.TFRT.IN>, WHO. Country profiles 2013. Available at: http://www.who.int/gho/maternal_health/countries/en/ UNDP 2015 Available at: http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/AFG.pdf

Table 7 demonstrates that some of these countries were either poor or have been through levels of conflict and yet they have still succeeded in implementing basic health care particularly around RH. Unlike the information provided in the Table 7, some reports demonstrate that there are inconsistencies in the estimated maternal mortality ratio, proportion of ANC visits and Total Fertility Rate in Afghanistan.

Data from various Afghan surveys (AMS 2010, AMICS 2010-11 and NRVA 2011-12) show that the maternal mortality ratio is 372/100,000 live births corresponding to a lifetime risk of 1 in 32 maternal deaths from maternal complications, and the fertility rate is 6.6 per woman. In some other reports, the estimated ratios of maternal mortality in Afghanistan ranges between 396, 400, 460 and 500 per 100,000 live births (Zeid 2015, Sen & Mukherjee 2014, UNDP/AFG 2015, Sen & Govender 2014, Tangcharoensathien 2014). For instance, the 'Trends in maternal mortality' report of WHO (1990-2015) estimated 396/100,000 maternal mortality per live births (Zeid 2015).

What these variable estimates show is that demographic information and maternal mortality census data is based on estimated figures and there is no reliable and systematically consistent census data because Afghanistan does not have a proper civil registration system with official records listing causes and dates of death and dates of births and marriages (Rasekh 1998, UNDP/HDI 2013&2015, NRHS 2009, Zeid 2015, Alkema 2015).

Since Afghanistan is a fragile state, the southern and southeastern regions have not been included in the 'Afghanistan Mortality Survey' due to insecurity. Data for the survey (AMS 2010) was compiled from household members' interviews (AMS 2010) in secure provinces of Afghanistan with the support of many international organisations. For instance, the Indian Institute of Health Management Research (IIHMR), ICF Macro, UNFPA and WHO provided technical support, and the United States Agency for International Development (USAID), the United Nations Children's Fund (UNICEF), the United Kingdom Department for International Development Health Metrics Network (UK DFID/ HMN) provided financial support.

From conversations within the MoPH staff (2014), it has become certain that some donors may have been boosting the figures to make the results look better. However the statistical unreliability of the 'Afghan Mortality Survey' is not acknowledged and is used as valid

statistical data internationally (Sen & Mukherjee 2014, Sen & Govender 2014, Tangcharoensathien 2014, WHO, UNICEF, UNFPA, WB and the UN Pop Div. 2015) Therefore, some international organisations clearly indicate that they do not trust the (AMS) report and that the MMR is probably likely to be much higher than stated.

Moreover, the Ministry of Public Health/ Health Management Information System office (MoPH/HMIS) in its annual report (2015) addressed the issue of over-reporting (100% or more than 100%) in terms of the ANC and PNC visits, institutional childbirth and referral system. Therefore, they expressed concern about the health statistics' databases, which often remain unreliable because there are inadequate comprehensive reporting systems to improve the quality of data.

In many low resource and fragile states, including Afghanistan, few women receive the recommended four ANC visits and the same applies to post-natal care (PNC) (WHO 2010a). It is reported in the Afghanistan health indicator that only 15% had received the recommended 4 antenatal visits (HNN 2010, Countdown to 2015) and less than 25% receive PNC services (WHO/AFG 2012, countdown to 2015). According to Ministry of Public Health/Reproductive Health Directorate (MoPH/ RHD) in some provinces, ANC and PNC visits are reported through the RBF (Result Based Financing) project.

It is evident that health facilities tend to demonstrate that they have met their targets in order to be eligible for salaries and funds for continuation of their work (MoPH/ RHD 2015). The RHD is alarmed about such project policies, which leads to under-reporting of ANC 2,3, and 4 visits, because all ANC visits are just reported as the initial visit. In addition, in many maternity health facilities, PNC is not registered as a first visit, right after childbirth. Therefore, according to the reproductive health directorate, every international organisation that provides financial support to health facilities has its own system of designed reporting and ANC and PNC visiting programs (MoPH/ RHD 2014).

Some studies point to poor health management and referral systems, a lack of operative and diagnostic equipment and medicine, costs of travel and fees for private health services, unpaved roads and the distance of health facilities from rural communities that increases inadequate access to SRH care facilities (Hampshire 2003, Arps 2009, Sesia 1997, NRVA 2011/2012).

Relying on international financial and technical support, the MoPH had concerns over the reduction of external aid for the reproductive health programs after 2008 due to increased levels of insecurity in many provinces of Afghanistan (Dalil 2014, Newbrander 2014). Indeed the major concerns are in terms of no guarantees for sustainable and higher quality health service provision due to shortages of medical resources, a lack of infrastructure and insecurity resulting in the closure of health facilities. All this impedes women's access and uptake of SRH services (Dalil 2014, Howard 2014).

Moreover, corruption is a prominent issue that impacts on SRH service uptake (Cockcroft 2011). In the public health facilities, SRH services are offered free of cost although, HSPs often demand fees for services and medication. As a matter of fact, health inequality emerges when a patient from a lower socioeconomic background is mistreated at the health facility and less attention is provided to poor or less wealthy users. However a patient who is acquainted with a health professional or gives tips to health staff receives support. Sometimes, patients might receive proper SRH services if they are recommended by a HSP (Rahmani & Brekke 2013, Cockcroft 2011).

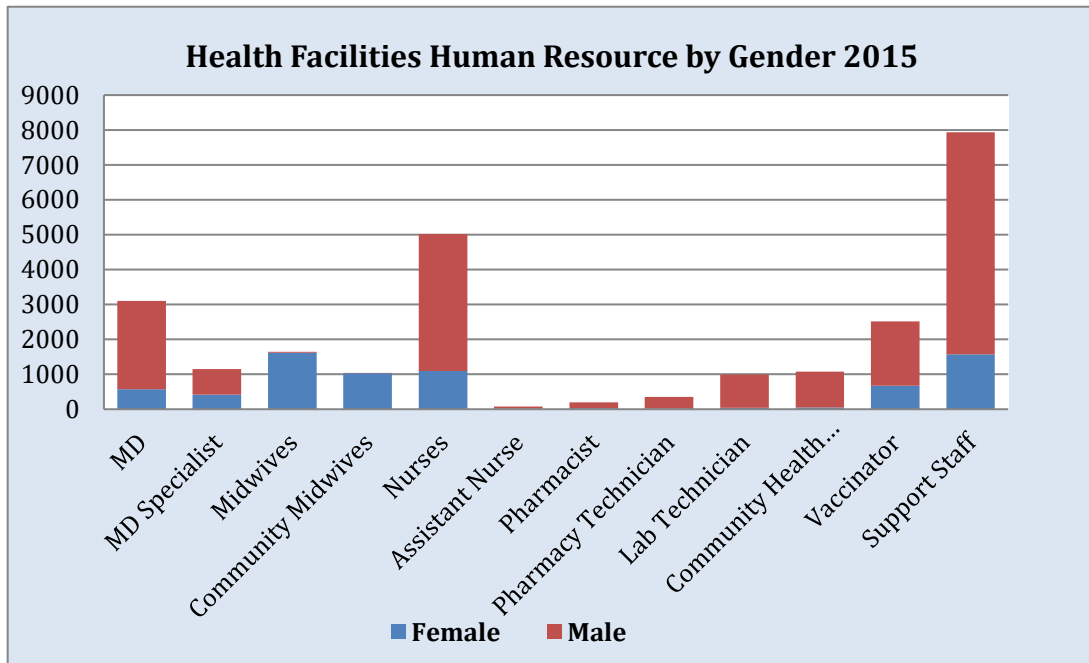
A study by Todd and Ahmadzai in 2008 indicated that one of the reasons for poor SRH service uptake and provision is the knowledge transfer gap between health providers and patients. Even if this is overcome, low ANC and PNC attendance leads to low levels of knowledge amongst women around safe motherhood and maintaining a healthy pregnancy. In combination, as a result of higher fertility rates (five births or more/ woman), the chances of pregnancy complications and maternal mortality and morbidity are increased (UNICEF 2011, HNN 2010, NRHS 2006-2009, Todd 2008).

The above discussions contain an implicit assumption that there are an inadequate number of female health providers (doctors, nurses, midwives, trained birth attendants), especially in remote localities where people demand a female health provider (Hadi 2012, UNICEF and MoPH 2000). The HMIS report (2015) clearly shows that there is at least one female HSP in 20% of health facilities but 80% of health facilities do not have female HSPs, especially in Helmand, Ghor, Khost, Kunar, Paktika provinces.

The disparities in the proportion of male and female health service providers indicated in

the HMIS report (2015) that currently 28% of females and 72% males work in the health sector and these are subject to significant status differentials. In other words, the ratio of female health service providers per male health service providers is 0.38. Figure 8 provides detailed information on gender inequality in the Afghan health sector.

Figure 8. Gender Disparities at the Health Facilities (2015)



Source: MoPH/HMIS 2015

The Figure 8 on gender disparity at the health facilities demonstrates that there is a health human resource deficit in the health sector and the proportion of male HSPs is higher than female HSPs.

It also shows the differences in statuses and professions. For instance, there are only 573 female MD and 417 MD specialists in comparison to 2533 male MD and 730 MD specialists. There are no female nurse assistants, pharmacists, pharmacy and lab technicians and community health service providers. Hence, figure 8 infers that insufficient numbers of female HSPs hinder women’s access to proper and higher quality health services.

Overall, despite the fact that Afghanistan is now classified as one of the countries ‘making progress’, Afghan women’s health and well-being are still under threat. Many factors including: insecurity and fragility, poverty, insufficient health resources, disparity of SRH projects, reliance on international funds and unreliable statistical data due to the lack of civil registration and surveillance systems, and many other underlying factors, hinder Afghan women’s access and uptake of higher quality SRH services. The Afghanistan MoPH have agreed to comply with global policies, but actually in practice there are many reasons behind their difficulties in implementing it.

4.7. Sexual and Reproductive Health Service Status in Kabul

Kabul is the capital of Afghanistan with an estimated settled population of 4.5 million people (CSO 2015-16). These figures may not be reliable since many people have been displaced from various provinces of Afghanistan to the Kabul districts due to conflict, instability and lack of jobs. The increasing size of the displaced population means that more health facilities are needed to provide at least basic health services.

The MoPH, with the collaboration of international organisations and the private sector, support 254 health facilities (Basic Health Centre, Comprehensive Health Centre, District Hospital, Special Hospital, Sub-Health Centre, Mobile Clinic and other) in 15 districts of Kabul (HMIS 2015). Table 8 represents health facilities by implementers.

Table 8. Kabul Health facilities by Type and Implementers

Implementer	BHC	CHC	DH	SH	Sub HC	Mobile clinics	Other	TOTAL
MoPH	37	25	3	13		8	8	94
BRAC	25	10	3		2			42
Private							49	49
Emergency				1			8	9
MSF			2					2
ARCS			1			2		3
Others	14	3		8	3	12	9	49
MSI							4	4
AFGA						2		2
TOTAL	76	38	9	22	5	24	78	254

Source: HMIS 2015

Table 8 shows that MoPH, BRAC and private sector are the main health service providers in Kabul. There are only 94 MoPH supported health facilities and the private sector in 49 health facilities mainly providing secondary health care services.

In Kabul, there are 45 non-governmental organisations including BRAC and MSF that work as implementers to provide technical support to 109 governmental health facilities (HMIS 2015). Each implementer provides reproductive health services according to their project objectives, which could lead to discrepancies in the higher quality and/or availability to reproductive health service provision. For instance, MSF provides contraceptives within the health facilities whereas the MSI (Marie Stopes International) marketing team sell the contraceptives products door to door.

Health facilities within Kabul are not allocated according to population statistics and health needs. For instance, according to WHO guidelines, for every 50,000 people there should be 4 Basic Health Centers and 1 comprehensive health centre whilst, in reality this does not occur. Within the specific districts that are the focus of this study, two District Hospitals are located in district 9 (Dashte-e-Barchi) and 12 (Ahmad Shah Baba) and technically supported by the MSF (Médecins Sans Frontieres) organisation. A large proportion of patients cannot afford the fee for services in private health facilities, and when they suffer from serious SRH issues they go to a public/ governmental health facility, which adds to the overcrowding. The senior staff of health facilities states that the foremost reason for overcrowding in the health facilities is poverty.

A health advisor in the MSF-funded Ahmad shah Baba district hospital mentioned that MSF aimed to provide medicine, equipment and health services for 264,000 people in the district hospital. However the displacement of people from various parts of Afghanistan has doubled the number of patients. The overcrowding impacts on the higher quality of health services due to the insufficient number of health service providers and lack of medicine in the BHC and CHCs. In Bagrami CHC, for instance, 200 outpatients demand medicine and proper treatment on a daily basis. However according to the Bagrami district CHC officer they have too few health service providers and medicine. He said:

“I am a pediatrician however I perform multitasks. I am the officer of this clinic I visit and conduct ill children’s treatment, distribute medicine and treat TB patients. We only provide 6 Paracetamol, 20 tablets of Ferrous for each maternity patient. We cannot perform pregnancy tests because our technician left the job due to his home distance. He had minimal salary so he could not afford the cost of transportation.”

This comprehensive clinic did not have a female vaccinator to provide TT (Tetanus toxoid) vaccines to pregnant women. After a few months of asking the MoPH to send a vaccinator, finally they introduced someone who was a part-time law college student. However she was not a trained vaccinator, she obtained the job because a high-ranking official recommended her through an NGO. Table 9 demonstrates the number of Bagrami district CHC and Pul-e-Khoshk BHC staff and the required health service providers.

Table 9. Staff list of Bagrami CHC and Pul-e-Khoshk BHC

Staff required In each Clinic	Male	Female	Presently working	Bagrami CHC		Pul-e-Khoshk BHC	
				Male	Female	Male	Female
Doctor	1	1	Doctor	1	1	1	-
Midwives		2	Midwives	-	1	-	1
Nurse	1	1	Nurse			1	-
Vaccinator	1	1	Vaccinator	1	1	1	1
Health Mobilizer	1	-	Health Mobilizer	-	-	1	-
Lab Technician	1	-	Lab Technician	-	-	1	-
Pharmacist	1	-	Pharmacist	-	-	1	-
Administrative clerk	1	-	Administrative Clerk	-	-	1	-
Cleaner	-	1	Cleaner	-	1	-	-
-Security guard	3		Security guard	1		1	
Total		16	Total		7		9

The BHC and CHC obtain medicine supply quarterly however, many routine and ordinary tests such as haemoglobin test, pregnancy tests, Malaria, Typhoid, STIs tests are not done in CHCs. During an interview, the head of Pul-e-khoshk CHC mentioned that they perform lab tests in the clinic and provide medicine selectively, in order not to build up a shortfall of medicine. During my observations, it was revealed that many patients were conducting lab tests in private clinics and were returning to the Pul-e-khoshk CHC to obtain medicines.

In the same way, MoPH supported Dashte-e-Barchi DH until 2014 and the quality of reproductive health care services was very poor. For instance, they usually ask patients (who are often very poor) to bring in their own childbirth kit. In addition, they ask patients to bring gloves for vaginal examination, drip kit, canola, gas pad and other hygienic tissues, syringes and oxytocin ampule. Only 10 tablets of Paracetamol, Ferrous (Iron) and Vitamin A are provided to patients.



Photo 14. A woman is waiting to receive a prescription from the Pul-e-khosk CHC midwife after sharing her lab test results for STIs, which was done in a private clinic.

This chapter's review of SRH status in Afghanistan and Kabul demonstrated that there are numerous obstacles that hinder higher quality SRH care service uptake and provision, not only in rural but also in urban areas like Kabul. From the above information, it may be stated that there is a complex web of issues and barriers to the implementation of reproductive health policy and guidelines. It is therefore important to explore reproductive health policy (RHP) and compare it with patients' health conditions and needs.

Chapter Five

5. The National Reproductive Health Strategy Design and Development Process

The Afghan Ministry of Public Health (MoPH), under the influence of interest groups and international organisations, started to try to reduce the burden of high maternal mortality ratio in 2001. The WHO Reproductive Health model, which was produced for low-income countries to improve maternal health, mainly in the African Region (WHO Regional Office for Africa 1998-2007), has been tailored over the years to fit an Afghan context. The MoPH, with the coordination and support of WHO and the involvement of different donors, stakeholders, multilateral and UN organisations developed The Afghan 'National Reproductive Health Policy and Strategy' (NRHP&S 2006-2009).

In 2011, twelve working groups of the Reproductive Health Task Force (RHTF) revised this document and adopted an integrated approach for implementation between 2012- 2016. Working groups of the RHTFs worked around 4 months and conducted three workshops entitled 'The Principal Contributors to the Revised Strategy' over a year to integrate the feedback into draft RH Policy and Strategy. In addition, another objective for twelve working groups was to take steps to effectively implement RHP over the next five years and plan long-term goals.

5.1. The Two Principles of National Reproductive Health Policy and Strategy

The principle aims of RH Strategy are based on guiding principles (core values e.g. human rights, equity, gender and culture) and operational principles.

1) Guiding Principles

Core Values

1. Human rights: the RH Strategy aims to promote the rights of people especially women to uptake standard health care services.

2. Gender: addressing the health of marginalised women and actions against any discrimination in accordance with RH Strategy supports for gender equity.
3. Equity: RH aims to prioritise the health needs of under-privileged people, particularly in rural areas in order to reduce health inequalities.
4. Culture: by considering the sociocultural aspects of Afghan context, RH Strategy aims to apply culturally sensitive approaches to addressing maternal and child health and work with community members, including women and families (NRHP&S 2012-16).

In summary, the MoPH supports actions to reduce gender inequality and discrimination in the health sector and improve HSPs knowledge of RH issues and advocacy. The policy also seeks to promote reproductive health rights through working with communities and families to identify inappropriate socio-cultural issues and address them through mass media (NRHP&S 2012-16, Samar 2014).

2) Operational Principles

The major operational aims are to respond to increasing health needs, improve reproductive health conditions and promote an effective monitoring and evaluation system. The reproductive health policy (NRHP&S 2012-16) expanded its focus from 'maternal mortality and morbidity reduction' to the provision of higher quality reproductive health services to individuals through their life cycles; seeking families, communities, implementers and private sector's support; provision of family planning facilities, treatment of sexual transmitted infections (STIs), HIV (Human Immunodeficiency Virus) consultations and reproductive tracts infections (RTIs); and detection and treatment of breast and cervical cancers. Moreover, implementing infertility and obstetric fistula treatments were included as a long-term goal.

Information from the National Reproductive Health Policy, Strategy and BPHS was used to construct the flow chart in Figure 9 below, which summarises the policy reform process:

Figure 9. Summary of RH Policy and Strategy Development and Reform Process Through National Consultative Meetings

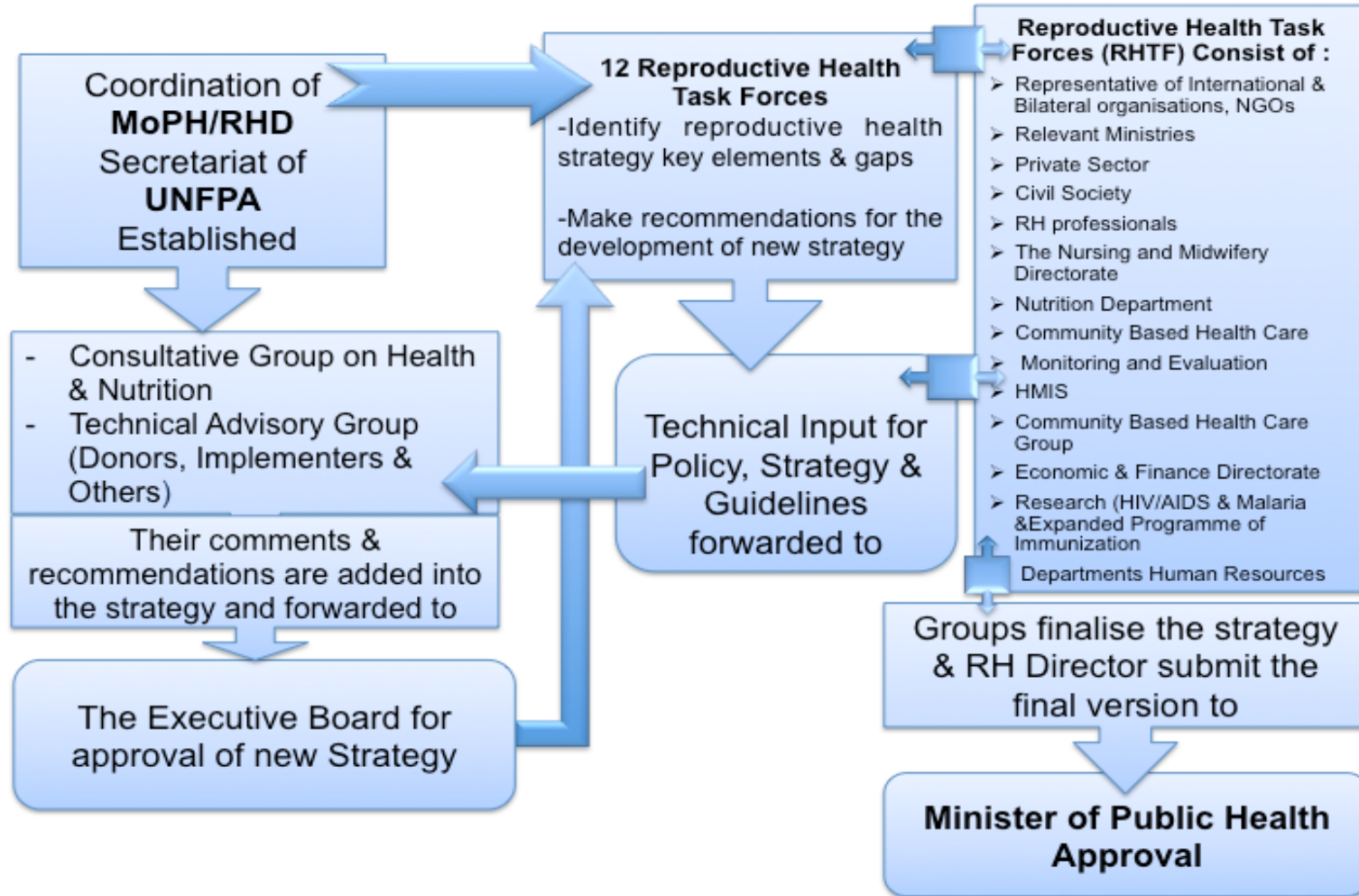


Figure 9 depicts how the MoPH, with the technical support and observation of UNFPA, established 12 reproductive health task forces (RHTFs) to set policies and standard and to provide technical output on reproductive health topics. Each of the RH task force includes RH directorate staff and representatives of international, bilateral, NGOs and private health provision sector, RH professionals and implementing organisations. It is also mentioned in the RH Policy/Strategy that relevant ministries and civil society members were also part of these twelve task forces.

The RHTFs provided inputs on reproductive health issues and priorities. They worked on the reform and implementation of reproductive health policy, strategy and protocols. Their recommendations were forwarded to the Consultative Group for Health and Nutrition (CGHN) and the Technical Advisory Group with the partnership of donors, implementers and coordinating ministries. These two groups were established by MoPH to review RH issues and identify the gaps within the draft RH policy, strategy and protocols. The report was not widely circulated amongst the Executive Board or consulting contributors before being sent by the chairperson of the Task Force to the Minister of Public Health for approval and signing off.

Twelve task groups and collaborative partners reviewed the consistency of the amended draft policy and strategy after translation from English to Dari and Pashto languages. In the last stage, the RHTFs reviewed the last draft version of National RH Policy and added relevant feedback. Consequently, the Chairperson of the Task Force (Director of RH) sent the finalised version to the Minister of Public Health for approval and signature. Approved RH Policy and Strategy were published with the support of Maternal and Child Health Division, Bureau for Global Health-U.S. Agency for International Development USAID.

Whilst this process initially appears to be robust, there are many ministries and other organisations whose involvement would have greatly strengthened the effective implementation of this strategy.

5.2. Key Collaborators (Actors) Role in Implementation of RH Strategy

The RH Strategy aims to improve the RH of Afghan families through provision and the increased access and uptake of integrated RH services in collaboration with community

members, development stakeholders and the private sector. Action plans are developed based on three sources of annual work plans:

- Each unit of the Reproductive Health Directorate (RHD) develops annual work plans.
- The provincial public health offices in consultation with their implementing NGOs develop their annual work plans.
- The implementing NGOs develop their own work plans to contribute to the provincial annual work plan.

It is stated in the RHP that the action plans will be based on the RH priorities and direction from MoPH and collaborative stakeholders (mainly donors and technical support agencies).

To ensure significant amendments to RH draft policy and strategy documents and the successful implementation of NRHP&S, the collaboration of various units including MoPH / RH staff, associate health professionals, international, bilateral and NGOs (media, faith based, professional and community-based organisations), relevant ministries, Parliament and other partners were needed beyond Task Force membership. For instance, the RH policy calls for collaboration of:

- Ministry of Women's Affairs (MoWA) to review maternal and neonatal health (MNH), Family Planning (FP), Gender issues, Sexual Transmitted Infections (STIs) and HIV&AIDS advocacy programs.
- The Ministry of Education (MoE), Ministry of Higher Education (MoHE) and Ministry of Communication and Information Technology (MCIT) to review and coordinate in Information, Education and Communication (IEC), Behavioural Change Communication (BCC) and inclusion of health curriculum in the schools and higher education.

The MCIT signed a memorandum of understanding with the MoPH in terms of Telemedicine in August 2015 with the aim of connecting Afghan medical universities with other countries to obtain cutting edge knowledge. In addition, this ministry showed commitments to connecting national health facilities to the main hospitals and international health institutions; in order to improve higher quality health services and allow people in rural

areas to access medical services (MCIT 2015). These two ministries, however, were not parties to the design of the RH P&S nor were they consulted on a draft version before finalisation of the Policy. The following ministries were also not part of the RH P&S development process. Their significant role in terms of RH Policy implementation has also been addressed in the RH Policy (NRHP 2012-16).

- Ministry of Agriculture, Irrigation and Livestock and Ministry of Commerce and Industry could support MoPH/RHD by reviewing topics in relevance to the food supplements for women and children, their nutritional status and substitution of breast milk.
- Ministry of Rural Rehabilitation and Development could help ensure health services are expanded in remote areas and people have access to health facilities.
- Ministry of Justice and Ministry of Hajj and Religious affairs could play a significant role in the implementation of RHP&S based on promotion of the rule of law (maternity leave laws) and Islamic views.

International and bilateral agencies, for instance UN agencies (WHO, UNICEF, UNDP, UNFPA), United States Agency for International Development (USAID,), Japan International Cooperation Agency (JICA), World Bank (WB), European Union (EU), Non Governmental Organisations (NGOs) or health service implementers were acknowledged as the key stakeholders. They have not only provided technical and financial assistance in the development and reform of NRHP&S but also reinforce the significant implementation of RHP into practice by the provision of sustainable in-service training to health professionals through their implementing organisations.

However the in-service training is ineffective according to some HSPs. For instance, when interviewed some HSPs who had undergone 7 days training for GBV (Gender Based Violence) could not define what GBV means. Some HSPs reported that they have not absorbed the issues because the topic was translated from a Western context and there were no relevance to the Afghan society. Others reported that they could not put GBV and mental health training in to practice because they do not record and refer any survivors to violence or patient, with mental illnesses to the psychosocial counsellors, while some other

HSPs do not relate to the international organisations' background and activities. A midwife (107) for instance, expressed her experience of taking part in MSF training sessions.

“SANOU is a training that explains about MSF activities. There are many sessions of it. In a few days I have to participate in module 5 or 6 but I do not have anything in my mind because much information is in English. In one of the SANOU training sessions they showed a film about MSF. Someone from IPD section came and slept till the end of film. Most of us also had a nap. Everyone was happy that they at least saw the last minutes of the film. I don't know why we have to take part in such training.”

To improve knowledge exchange and build HSPs' capacity, the Nursing and Allied Health Institutes, the Afghan Society of Obstetricians and Gynaecologists (AFSOG) and the Afghan Midwifery Association (AMA), which all contributed to the reform of RH policy and strategy, could play an important role in evaluating training sessions and making them more effective.

Reproductive Health Policy (components 4 and 6.8 and strategic approach 2.6) recognises the essential role of the private sector in maintaining National RH care standards and providing pharmaceuticals and family planning methods. The association of key collaborators such as health professionals and the private sector could play an important role in the implementation of RHP into practice. However it is not possible to find evidence of private sector involvement, by providing feedback or contributing to development process of RHP&S.

The role of various entities and sectors in terms of the RHP development process and successful implementation of RHP were identified in the NRHP&S however the role of public and/or patient consultations, particularly adolescents opinion and beliefs (NRHS 2012-2016) about the development, reform and implementation of this Policy and Strategy were not taken into account.

Moreover, information from the RHP&S development and reform process showed that the complex relationships among various actors are known to be strained, and power differentials are active barriers to good policy development and implementation. It is important to mention that according to the HMIS office report (2015) there are ten main donors, around 50 national and international implementing organisations and 49 private

health provision facilities actively providing technical and financial support and RH care services to Kabul province residents. However there are numerous national and international organisations supporting the implementation of RH Policy in other provinces of Afghanistan.

An analysis of the key collaborators' roles and their relative power (Walt & Shiffman 2008) at the RH decision-making and RH Policy implementation level is provided in Appendix (E). Table 9 summarises the assessment of the main players' roles and power in shaping the agenda or reinforcing RH Policy improvements. It is significantly important to mention that my assessment of the effectiveness or ineffectiveness of organisations' roles and power are on the basis of RHP&S analysis and literature review, and data obtained from interviews and FGDs with many of aforementioned organisations.

Table 10. Summary of Key Collaborators' Role for RH Policy Development Process and Implementation Power

No	Name of Organisation	Type	Role and Power	
			Policy Development Process	Implementation of RH Policy Components
1	USAID: United States Agency for International Development	International Donor	Active Role in Policy Development	Greater power for Immediate & Long-term implementation of all RH Policy components
2	JICA: Japan International Cooperation Agency	International Donor	Active Role in Policy Development	Greater power for Immediate & Long-term implementation of some RH Policy components
3	UNFPA: United Nation Population Funds	International Donor	Active Role in Policy Development	Greater power for Immediate & Long-term implementation of all RH Policy components
4	UNICEF: The United Nations Children's Fund	International Donor	Active Role in Policy Development	Greater power for Immediate & Long-term implementation of all RH Policy components
5	WHO: World Health Organisation	International Donor	Active Role in Policy Development	Greater power for Immediate & Long-term implementation of all RH Policy components
6	CIDA: Canadian International Development Agency	International Donor	Active Role in Policy Development	Immediate & Long-term implementation of Some RH Policy related to Women's Rights, women equity and empowerment
7	Global Fund	International Donor	Active Role in Policy Development	Long-term implementation of Some RH Policy related to TB, HIV&AIDS and Malaria prevention and treatment and HSS
8	European Union	International Donor	Active Role in Policy Development	Greater power for Immediate & Long-term implementation of Some RH Policy related to Women's psychosocial well-being, women empowerment
9	WB: World Bank	International Donor	Active Role in Policy Development	Greater power for Immediate & Long-term implementation of Some RH Policy components
10	AKDN: Aga Khan Development Network	International donor & Implementing Partner	Active Role in Policy Development	Effective Long-term implementing power
11	BRAC	International Implementing Partner	Active Role in Policy Development	Effective immediate and long-term RH Policy implementing power
12	GAVI-HSS: Global Alliance for Vaccine and Immunization Health System Strengthening	International Donor	No Substantial Role	Greater power for Immediate & Long-term implementation of some RH Policy related to immunisation and HSS
13	MSF: Medicine Sans Frontier	International Implementing Partner	No Substantial Role	Very effective immediate and long-term RH Policy implementing power
14	REACH	International Implementing Partner	No Substantial Role	Effective BCC/ IEC program implementation power
15	MSI: Marie Stopes International	International Implementing Partner	No Substantial Role	Effective implementation power (if contraceptives distributed free of cost)
16	SHARP: Strengthening Health Activities for the Rural Poor Project	International Implementing Partner	Non decision-maker	Ineffective implementation power (had a short term project)
17	IMC: International Medical Corps	International Implementing Partner	No Substantial Role	Effective immediate and long-term RH Policy implementation power for mental health and psychosocial support.
18	IPSO: International Psychosocial Organisation	International Implementing Partner	No Substantial Role	Effective implementation power

19	AFGA: The Afghan Family Guidance Association	National Implementer	Working Role in RHTFs	Effective immediate and long-term RH Policy implementation power in terms of RH services, free contraceptives distribution, psychosocial counselling and sexuality education and promoting SRH awareness through Religious leaders
20	Health Net TPO	National Implementer	No Substantial Role	Effective immediate and long-term RH Policy implementing power in terms of community resource mobilization, peoples awareness about health, hygiene and human rights according to Islamic beliefs, reduction of violence, women's empowerment and health staff capacity building
21	Civil Society	National Entity	No Substantial Role	Ineffective implementation power
22	WAW	National Entity	No Substantial Role	Effective SRH and Rights implementation power
23	AIHRC: Afghanistan Independent Human Rights Commission	National Entity	No Substantial Role	Ineffective implementation power
24	Mass Media	National Entity	No Substantial Role	Ineffective implementation power
25	Private Sector	National Implementer	Working Role in RHTFs	Effective immediate and long-term RH Policy implementation Power
26	Ministry of Woman Affairs (MoWA)	Governmental Entity	Working Role in RHTFs	Ineffective implementation power
27	The Ministry of Education (MoE)	Governmental Entity	No Substantial Role	Effective BCC/ IEC program implementation power
28	Ministry of Higher Education (MoHE)	Governmental Entity	No Substantial Role	Ineffective implementation power
29	Ministry of Communication & Information Technology (MCIT)	Governmental Entity	No Substantial Role	Effective Telemedicine program implementation power
30	Ministry of Justice (MoJ)	Governmental Entity	No Substantial Role	Ineffective implementation power
31	Ministry of Hajj and Religious affairs (MoHRA)	Governmental Entity	No Substantial Role	Ineffective implementation power
32	Ministry of Agriculture, Irrigation Livestock	Governmental Entity	No Substantial Role	Effective implementation power in terms of food supplement distribution to pregnant women who suffer from malnutrition
33	Ministry of Rural Rehabilitation & Development (MRRD)	Governmental Entity	No Substantial Role	Effective implementation power in terms of clean drinking water and sanitation

Table 10 provided an assessment of the relative power of the groups that were included and those that were not included in the NRHP&S development, reform and implementation processes. It is important to mention that in my former work with USAID, UNESCO and BBC, I had good access to many local health organisations such as, Medica Mondiale Afghanistan, SHUHADA, HADAAF, WADAN, Raozana, CARE, CHA, SHRDO etc., who were involved in RH and human rights sector in Kabul districts and other provinces. Those organisations were not included in the analysis due to the lack of data or discontinuity of some projects in recent years.

Moreover, table 10 was restricted to SRH Policy reform and implementation analysis, distribution of responsibilities and organisations relationships (Walt & Shiffman 2008). It's important to note that these entities' roles and power were purely discussed in terms of their adopted roles within the health system, not in terms of their wider political power. Omitting such considerations masks differentials in power between entities, but a full analysis of these entities are beyond the scope of this research.

International organisations mainly donors seemingly contributed equally to the RHP development Process. From the analysis of entities' power it can be shown that USAID, potentially has hegemony in decision-making over how roles, projects, finances should be allocated within the health system, due to its size and potential influence resulting as an arm of an occupying military power. USAID runs a bidding system for its projects, and licences for implementing international projects are issued through Ministry of Foreign Affairs. However JICA, WB, EU, CIDA and Global Fund do have decision-making power over financing and contracting for some specific projects. The United Nation (WHO, UNFPA, UNICEF) organisations play a crucial role in terms of technical support and funding for some projects and surveys.

Having discussed the role of international implementing organisations, MSF, BRAC and AKDN are the three main organisations that play a significant role in terms of implementing RH Policy components. MSF provides free RH services including emergency obstetric health services in four provinces of Afghanistan (Kabul, Konduz, Helmand and Khost). BRAC provides technical and financial support to 42 health facilities in Kabul and they are not directly in touch with the Afghan population. The Aga Khan Development Network (AKDN) is active in many provinces of Afghanistan. Health projects are mainly implemented in rural vicinities e.g. around 132

community midwives were trained between 2004-2013 in Bamyan and construction of provisional hospitals started in 2012 in Bamyan and Badakhshan provinces (Palmer 2014, AKF 2012).

The Marie Stopes International (MSI) organisation primarily implements Family Planning projects (door-to-door product marketing) and supports safe-abortion. The level of acceptability among Afghan population is low, because according to my interview data, the majority of Afghan women prefer acquiring free reproductive health services, including free contraception, and become agitated when discussing forbidden issues such as abortion. In addition, the 'International Psychosocial Organisation' (IPSO) did not contribute to the RHP reform and develop process. This is the only entity that provides psychosocial support but due to financial constraints the organisation downsized its operations (in 2014), meaning its current operational activities are almost negligible.

According to this research data, the 'Afghan Family Guidance Association' (AFGA) and 'Health Net TPO' are the two main national organisations that play a crucial role in terms of implementing RH Policy components (1,2,3&6) but they do not have a decision-making power in terms of RHP development because they are also receiving funds from various international donors.

Referring back to the context factors (Table 8 in Chapter 4, p. 80), private sector runs 49 health facilities in Kabul, which is the second highest category of health service provision after MoPH. The RH Policy emphasizes more private sector involvement in RH service provision, laboratory and diagnostic services, family planning and pharmacy. However the private sector was not engaged in RH Policy and Strategy development process.

Mass media and civil society roles are not significantly acknowledged in terms of RHP&S development process and implementation. However they could play a role in terms of raising awareness and changing behaviour and also gaining acceptance for particular arms of the policy, which might be considered less socially acceptable. Moreover, mass media agencies avoid free broadcasting or publishing RH related awareness messages. For instance, only some private TV channels agreed to broadcast awareness video spots on young age marriage and pregnancy related complications, which were financed by UNFPA.

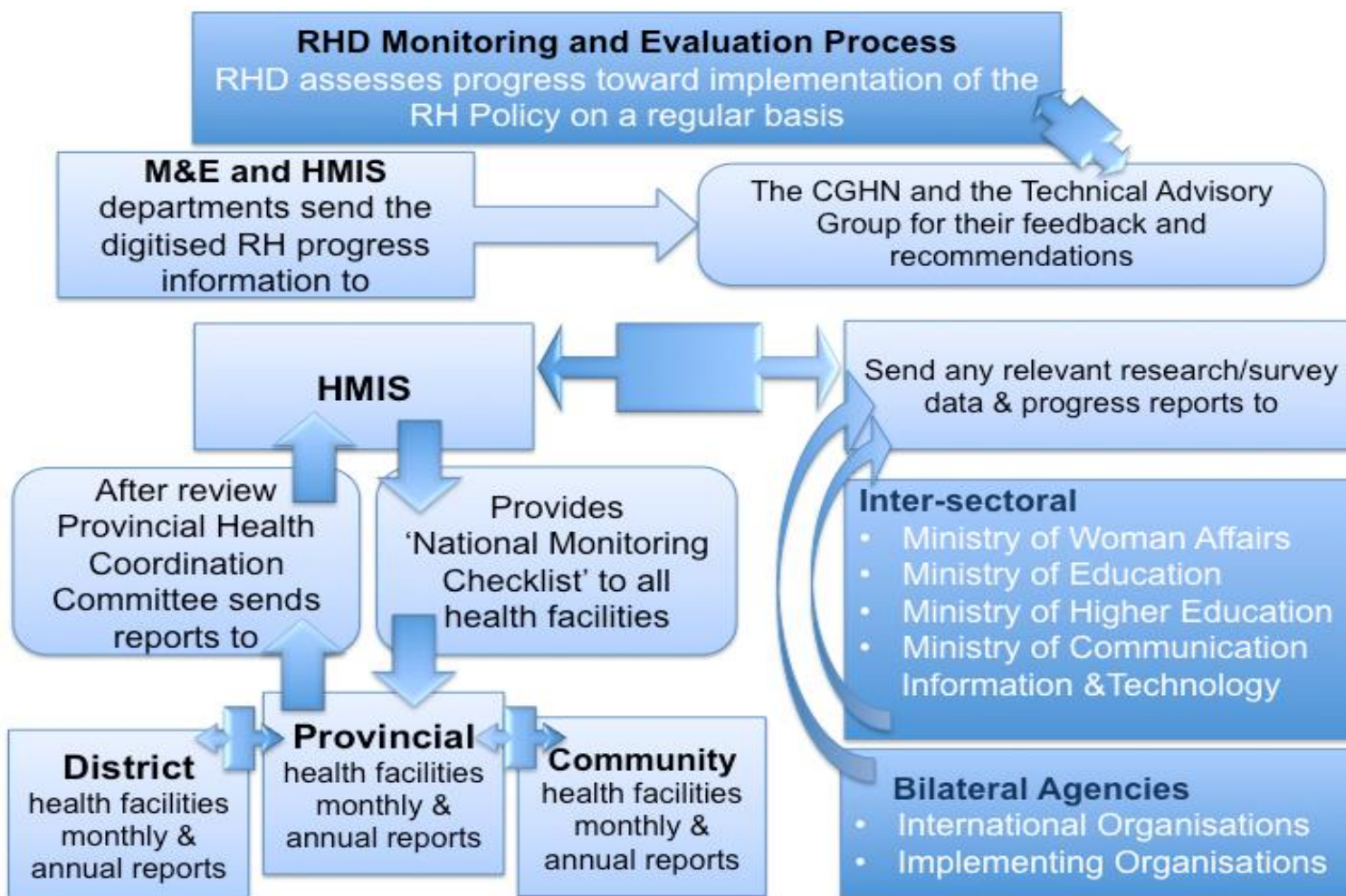
Likewise, in the RHP, it is mentioned that MoWA was part of RHTFs however other ministries did not play a significant role in the NRHP&S development process. In fact, ministries and some national organisations could be considered in theory key RH Policy implementers even though in practice their implementing powers are overlooked. I am aware that such considerations cannot ultimately be separated from the deeper questions of the longer-term development and effectiveness of the health system. However this degree of political analysis was beyond my current level of political science knowledge and skills.

5.3. Monitoring and Evaluation Process of Applicable Recommendation

It is reflected in the RH policy that the RH Directorate is responsible for conducting regular and close monitoring and evaluation of implementing organisations' activities, which could enable the HMIS (Health Management Information System) to obtain regular activity reports from implementing partners. In addition, another responsibility of the RHD, which is mentioned in the RH Policy/ Strategy, was to conduct periodic surveys and observation of health facilities. These two M&E actions ease evaluation of RH projects' progress and aid, planning and timely decision-making around both policy and strategy reform, and application of effective interventions.

The RH directorate oversaw the results of surveys {(e.g. Knowledge Attitude and Practice Survey of Increased Demand for Health Services Utilization in Afghanistan (KAP 2010), Multiple Indicator Cluster Survey (MICS), 2003, Afghanistan Mortality Survey (2010)} data collection expenditures and support surveillance and reporting system. Regular monthly progress reports are also normally sent through Provincial Health Officers (PHOs), Reproductive Health Officers (RHOs), collaborating ministries mainly (MoWA, MoE, MoHE, MCIT) and implementers to HMIS. I have summarised the reported process of monitoring and evaluation in Figure 10.

Figure 10. Summary of Monitoring and Evaluation Process of Reproductive Health Policy Implementation



Source: Reproductive Health Policy & Strategy 2012-16

Figure 10 demonstrates that the RH Directorate often obtains HMIS monthly and annually reports. The reports are usually provided in paper format because health facilities at the community, district and provincial levels receive hard copies of the 'National Monitoring Checklist' from HMIS. These health facilities do not have computers and all reporting is done by pen and paper. Even if some health facilities have a computer, the absence of power and Internet connections hinder proper reporting systems. Therefore the majority of health facilities rely on paper based reporting systems.



Photo 15: A shelf of Dashte Barchi DH Archive room

This creates data unreliability as many health posts at the community level and district health facilities do not send their paper based monthly and yearly reports to the provincial health coordination committee (PHCC) in a timely fashion due to the unpaved roads, lack of transportation facilities and more importantly insecurity particularly in the Southern provinces (HMIS 2015).

The PHCC review RH related Monitoring and Evaluation data and sends amalgamated reports to HMIS to ensure the on-going effective implementation of RH recommendations. Under such reporting systems the private health facilities activity reports are not logged or reported to HMIS. It is important to mention that HMIS digitises the reports and adds the data into their database for further analysis. HMIS and M&E departments will then send the reports to the Consultative Group Health & Nutrition (CGHN) and Task Advisory Group (TAG) for their feedback and recommendations (MoPH/NRHP&S 2012-2016).

It is stated in the RHP&S that if some inter-sectoral organisations such as ministries (MoWA, MoE, MoHE and MITC) and bi-lateral agencies (international donor and implementing organisations) in collaboration with MoPH conduct operational research or surveys, they share health related relevant results and/or reports with the RHD and HMIS department. However those organisations, which are not independently audited by MoPH, may 'skew' these activities or the outcomes of surveys.

After the annual review of RH service outcomes, recommendations are included in the revised RH related strategy, which aims to strengthen the higher quality of RH services. It is highlighted in the RH Policy that the establishment of RHTFs made the yearly review of RH policy and strategy possible. In fact, the RH policy and strategy were reviewed and were amended in 2012, based on the reported health needs assessments and applicability of interventions.

According to the NRHP&S quality assurance is a multifaceted issue and might be measured based on key collaborators' priorities. Despite this, the quality assurance tools for ensuring standard quality and sustainable RH provision, access to RH services and monitoring data from health posts to the national level have not been clearly alluded to the RH policy and strategy. I could not find evidence of whether MoPH/ RHD was using quality assurance techniques. In other words, the RH policy says there are standard tools available, but in all my inquiries I was not able to identify what these actually were in practice and whether anybody was routinely using them.

Together with data unreliability, the lack of quality assessment, inconsistent reporting processes, the lack of an electronic reporting system across public and private health facilities and insecurity all hinder an effective and comprehensive M&E and RH outcome measurement system (HMIS 2015) and undermine the ability of MoPH to

devise and implement annual revisions and amendments to the RH Policy and Strategy RH Resources Assessment (RHRA 2003).

5.4. Reproductive Health Policy Design and Development Weaknesses and Strength

Despite insecurity and lack of health resources, the establishment of BPHS and RHP&S (2006-2009) gave the MoPH/ RHD opportunities to improve reproductive health and encourage the implementation of effective interventions. In terms of positive operational outcomes, according to HMIS department, new and essential medicines were provided, equipment for health facilities was augmented and the number of trained midwives increased from 467 to 3000 over 15 years (HMIS 2015). The proportion of health facility based childbirth increased by one-third (32.4%) and at least one ANC visit increased by 60% between 2002-2015 (HMIS 2015). However the rates of women accessing quality reproductive health care services particularly ANC, PNC, family planning and childbirth still remain below the average in Asia.

A more mixed picture is seen in the extent to which RH Strategy (2012-2016) addresses the issue of gender inequality and discrimination. Although these are included professional ethics in terms of considering the rights of patients are not included, which, as subsequent chapters demonstrate, undermines trust and respect both amongst health professionals and between professionals and patients.

Another factor weakening the effectiveness of the RHP&S is the complete absence of knowledge exchange, feedback and involvement of private health sector representatives, civil society activists, economists, psychosocial specialists, anthropologists, and lay people (women and families), whose views could improve understanding of existing health issues and disrespectful and poor quality of SRH care services (WHO HRP 2014, Gupta & Gupta 2016). Involvement of these actors could help policy-makers identify the socio-cultural issues that hinder RH service uptake.

The RHP&S do demonstrate some awareness of their own limitations. The Strategy itself notes the following constraints: insecurity, lack of skilled female health providers, low level of RH awareness amongst various Afghan communities, lack of proper mechanisms for quality assurance and monitoring of private and public health facilities, lack of a standard reporting system particularly around maternal mortality and morbidity, an inadequate civil registration system (birth, death and marriage

records), no standard tracking system for measuring budget expenditure on health and a lack of sustainable RH services due to the reliance on international donors funds.

Whilst the acknowledgement of these operational constraints within the RH strategy is useful, weaknesses regarding the RHP&S process are not well addressed. For instance, any recommendation in terms of RHP&S development or any solutions to the long-standing constraints without seeking international donors help have not been translated into practice. For these reasons and those outlined above I concur with earlier writers' assessments (Buse & Mays 2012, Sabatier 2007), that the RHP&S development process was a narrowly focused, top-down bureaucratic exercise undertaken by specific authority groups.

It is important to note that I could not find evidence that the final version of the RHP after its completion had ever been circulated. It appears that the onus is on individual MoPH departments and other ministries to make their own efforts to search the MoPH website to find out what are their responsibilities are. Since the Afghan RHP&S were not distributed, obtaining relevant official documents was challenging and required personal contacts. At the time when I completed my data collection and left Kabul (May 22 2014), two years before the policy was supposed to expire, it was still in draft form and had not been officially signed and circulated to any other ministries.

To conclude, this chapter assesses the usefulness or value of the reproductive health strategy development and implementation process. The significant role and power of many collaborative entities are discussed in terms of their adopted roles within the health system. In addition, a lack of transparency and accountability in terms of healthcare services implementation and reporting systems for the public and private health facilities were also evaluated. The next chapter will evaluate the applicability of strategic components and elements of RH strategy in the Afghan context.

Chapter Six

6. Principle Elements of SRH strategy in Afghanistan and a Critique Thereof

6.1. The Elements of National Reproductive Health Strategy

The current Afghan National Reproductive Health Strategy (NRHS 2012-16), which was adapted from WHO RH model, comprises six principal strategic components, some of which remedy those missing from the previous RH Strategy (2005-2009). Some of the earlier relevant national strategy and policy statements, which are incorporated into the NRHS, are: The Afghanistan National Development Strategy (ANDS 2008-2013) and the Health and Nutrition Sector (HNS) strategy (2007-8 & 2012-13). The main strategic components of the revised RH strategy are summarised in table 11 below.

Table 11. National Reproductive Health Strategic Components and Approach

No	Strategic Component	Strategic Approach
1	Maternal and Neonatal Health	<p>1.1. Increase women's access to and utilization of antenatal care, skilled care, emergency obstetric and neonatal care (EmONC) and postpartum care</p> <ul style="list-style-type: none"> - Strengthen community-based health care delivery with community midwives - Increase number of skilled birth attendants - Improve distribution and deployment of SBAs - Promote the creation of family health action groups - Increase involvement of religious leaders (Khotba/ Preach) - Expand IEC/BCC activities in MNH <p>1.2. Improve the quality of MNH services, including EmONC</p> <ul style="list-style-type: none"> - Improve supportive clinical supervision - Strengthen in-service training - Improve the delivery of newborn care services <p>1.3. Improve monitoring and evaluation of MNH services and use of data</p> <p>1.4. Other Initiatives</p> <ul style="list-style-type: none"> - Pilot-test and evaluate new approaches to MNH services. - Advocacy for implementation of the new schedule of postnatal follow-up visits & Monitoring indicators
2	Birth Spacing/Family Planning (BS/FP)	<p>2.1. Strengthen the capacity to provide of a full range of FP methods (Training)</p> <p>2.2. Improve provision of BS/FP services at all levels</p> <ul style="list-style-type: none"> - Expansion of BS/FP services at health facility level - Strengthen reproductive health BS/FP commodity security <p>2.3. Expand Approaches for Community-Based BS/FP</p> <ul style="list-style-type: none"> - Strengthen linkages between health facilities and the community - Improve counselling of family health action group on postpartum family planning - Expand community-based postpartum family planning using CHWs - Strengthen referral and follow-up of the clients - Community-based distribution of BS/FP methods - Ensure quality of community health worker activities at the community level <p>2.4. Increase (IEC & BCC) for wider use of BS/FP</p> <ul style="list-style-type: none"> - Revise existing IEC/BCC BS/FP materials and develop new ones as needed - Develop standard IEC material distribution system in coordination with health promotion department - Reach community youth & married couples with BS/FP information & services - Increase involvement of community and religious leaders in FP and enlist their collaboration - Increase participation of elder women/mothers-in-law - Improve Interpersonal Communication (IPC) skills of health workers in all provinces <p>2.5. Strengthen monitoring and evaluation of BS/FP activities</p> <ul style="list-style-type: none"> - Improve monitoring of BS/ FP service utilization, quality of services and follow-up - Establish system whereby M&E data is fed back to users and utilized in decision making <p>2.6. Strengthen BS/FP services through the private sector</p>

3	Sexually Transmitted Infections and HIV/AIDS	<p>3.1. Improve the quality of STI clinical services</p> <ul style="list-style-type: none"> - Integrate STI management and HIV screening and primary prevention into BPHS and EPHS services - Monitor progress in STIs using the Health Management Information System (HMIS) - Identify resources for further STI/HIV/AIDS prevalence research <p>3.2. Build health workers' capacity in STI management</p> <ul style="list-style-type: none"> - Collaborate with implementing partners to allocate resources for the training of health workers in STI prevention, identification and treatment <p>3.3. Increase public awareness of STIs</p> <ul style="list-style-type: none"> - Collaborate with the IEC and HIV/AIDS departments on the development of IEC/BCC materials for STI prevention, including those that promote condom use
4	Strategic Approaches to Breast and Cervical Cancer	<p>4.1. Build health workers' capacity to detect the early signs of breast cancer</p> <p>4.2. Build health workers' capacity to identify cervical cancer in early stages</p> <p>4.3. In collaboration with implementing partners, plan a long-term, sustainable approach to the early detection and treatment of breast and cervical cancers</p>
5	Strategic Approaches Related to Other Issues (Obstetric Fistula, infertility)	<p>5.1. Increase awareness of fistula prevention, side effects and treatment among communities and health care providers</p> <p>5.2. Improve access to fistula treatment</p> <p>5.3. In collaboration with partners, identify appropriate, acceptable and accessible intervention strategies to reduce the incidence of primary and secondary infertility</p>
6	Cross-Cutting Issues (RH in Emergency Situations, Gender, Nutrition, Maternal Mental and Reproductive Health, IEC/BCC, Quality Improvement in RH Services, RH Research, Private Sector)	<p>6.1. RH in Emergency Situations</p> <p>6.2. Support an increase in awareness of gender issues and reproductive health rights among health workers</p> <p>6.2. Enhance women's decision-making role in relation to health-seeking practices</p> <p>6.3. Support and promote breastfeeding</p> <p>6.4. Support the promotion of micronutrient supplementation</p> <p>6.5. Inclusion of maternal mental health screening and psychosocial support in the pre- and in-service training curricula of health workers (obs/gyne, midwives and CMWs)</p> <p>6.6. Strengthening IEC materials production, distribution and use</p> <p>6.7. Quality Improvement in RH Services</p> <p>6.8. RH Research</p> <p>6.9. RH and the Private Sector</p>

Source: Table 10 reproduces the Afghan National Reproductive Health Strategy (2012-16)

Table 11 shows the primary component of RH is maternal and neonatal health improvement through increasing access to quality or standardised RH care service {ANC, PNC, and Childbirth, Emergency Obstetric Care (EmOC)}. The action plans for the implementation of primary RH component are to deploy and increase the number of Skilled Birth Attendants (SBAs), promote the formation of family action groups and increase the involvement of religious leaders. Moreover, the RHD plans to achieve quality assurance, reinforce in-service training to HSPs and incorporate the reports from proper M&E and pilot RH surveys into the forthcoming policy and strategy.

The RH Strategy particularly calls upon implementing partners to strengthen community based RH services via community health workers (CHWs), community midwives (CMWs), community health supervisors (CHSs) and family health action groups (FHAGs). It is expected that these will play a significant role in reproductive health Information Education and Communication or Behavioural Change Communication (IEC/BCC). To improve basic RH service uptake, this group will also be able to register pregnancies and provide relevant ANC information, along with the necessary supplements or medicines (vitamin A, iron foliate, and anti-malarial). The group will also check childbirth preparedness and the availability of home delivery kits and promote home-based PNC visits.

The second component focuses on Health Service Providers' (HSPs) capacity building in order to provide proper family planning or birth spacing (FP/BS) services. Expansion of birth spacing through provision of at least three methods of family planning {condoms, oral contraceptives and injecting contraceptives (Depo-Provera)} throughout Afghanistan is one of the core priorities of RH strategy. To expand and improve CHWs and Family Health Action Group (FHAGs) counselling skills and follow-up for the uptake of post childbirth family planning methods at the community level, the RH Strategy calls upon implementing partners to reduce the Interpersonal Communication (IPC) barriers and FP counselling deficit among HSPs and patients in all provinces. Under this component it is stressed that the involvement of family members (elderly women, mother-in-law), religious leaders and the private sector could also increase the uptake of FP.

The third component of the RH Strategy emphasises the importance of HIV/AIDS and STIs' diagnosis, management and follow-up. The improvement of higher quality STIs treatment services are expected to be evaluated through regular HMIS reports and routine RH care service provision. Therefore, the RHD called upon implementing partners to provide STIs management training to the HSPs and increase individuals' awareness around STIs and

HIV & AIDS transmission and prevention. Various organisations were also encouraged to conduct research around cervical cancer and STIs transmission and prevalence at the national level.

The fourth component of RH Strategy encourages the development of long-term, sustainable Strategic Approaches to the early detection and treatment of Breast and Cervical Cancer. The 'Afghan Mortality Survey' (2010) demonstrated that 8.4% and 16% of women's deaths were attributed to breast and cervical cancer accordingly. However there is a dearth of research data around the management and treatment of breast and cervical cancer in Afghanistan. The RH Strategy indicated that more attention should be paid to the diagnosis, management and treatment of such deadly diseases.

The RHD aims to raise women's awareness, particularly of breast and cervical cancer (breast self examination) through the primary action plan. Secondly, to achieve long-term goals for (IEC/BCC), both public and private health care service partnerships and training of HSPs would be crucial in terms of diagnosis (Visual Inspection with Acetic acid (VIA), detection of precancerous lesions, management (a freezing technique to destroy the lesions) and referral of patients who suffer from breast or cervical cancer.

The fifth component of the RH Strategy addresses the limited number of health professionals who can provide basic treatment for obstetric fistula and infertility. The causes of obstetric fistula are associated with the age of the first pregnancy, prolonged labour, home delivery and inadequate ANC and PNC visits. This health issue can be summed up as childbirth complications. At least 50,000 cases occur every year in Afghanistan. In other words, four in 1000 women suffer from the burden of obstetric fistula but few have access to proper treatment (MoPH & UNFPA 2015). The RH Strategy emphasises the need for the initial steps to be taken towards forming a National Obstetric Fistula Committee. MoPH/ RHD members, MoWA, other implementing partners and health professionals could join this committee and develop clinical guideline for patient identification and referral, and training programs for doctors to repair the fistula. This committee could also strengthen the obstetric fistula strategic approach through improving awareness amongst people and health professionals. With the collaboration of health professionals and implementing organisations, improving access to fistula monitoring and treatment is another priority.

Another element of component five addresses the need for counselling and the treatment of infertility. Since fertility rates are high amongst the majority of Afghan women, infertility has not been a matter of concerns. There is little information about primary and secondary

infertility although the causes of infertility in Afghanistan are known to be associated with STIs, STDs and TB, which are not treated properly and timely. Therefore, the RH Strategy aims to identify appropriate and acceptable interventions to reveal the prevalence of infertility among women aged 5-49. The RH strategy has no focus on high level technical infertility treatment but through the collaboration of MoPH counter-parts the primary detection of infertility and prevention of secondary infertility can be initiated.

Crosscutting issues such as RH in Emergency Situations, Gender, Nutrition, Maternal Mental RH issues, IEC/ BCC and RH Service Quality Improvement, RH Research and RH Private Sector, are highlighted as the sixth components of RH Strategy. The RH Strategy emphasizes the need to establish an action plan to enable HSPs' timely and good quality RH service provision in emergency situations at national and provincial levels.

In addition, the RH Strategy urges the implementing organisations and the Ministry of Education to help conduct gender related awareness programs, provide information and improve referral services both among women and HSPs. This will increase women's power related to GBV, sexual harassment and maternity leave. The lack of interpersonal communication and counselling (IPCC) skills among HSPs was also addressed in the RH strategy. For instance, more focus should be placed on HSPs awareness about patients' rights and Family Planning counselling about modern contraceptive methods. The role of HSPs can be strengthened to identify cases of violence and provide initial support to gender-based violence survivors (Garcia-Moreno 2014).

Two other key issues are firstly the prevention and treatment of malnutrition among women and children, which is brought about micronutrient supplementation to pregnant and breast-feeding mothers. Secondly, the RH Strategy calls on mental health departments to shift their focus towards those women before and after childbirth and post abortion who suffers from mental illnesses. This department is expected to develop guidelines and protocols to improve the management of maternal mental illnesses.

The RH Strategy also recommends the improvement of better quality RH services, through IEC/BCC for people. In addition, to enhance the quality of RH care provision, the application of evidence-based interventions through compiling RH research data is considered essential. The RH Strategy emphasises that the private sector plays a major role in RH provision. It identifies the significance of private sector health professionals'

involvement and participation in in-service training and the active participation of private sector representatives in Taskforce working groups.

It is clear that RH Strategy usually prioritises maternal and neonatal health interventions, Family Planning and the treatment of STIs. However less attention is paid towards prioritising interventions based on rights to decision making for SRH service uptake, the reduction of gender inequalities, vulnerabilities, mental illness and power imbalances which could impact on women's health and well-being and their health seeking behaviour (BPHS 2009, HNS 2012-13, CARE International 2004). It is evident, therefore, that the strategic components of RH strategy are applicable. However, given the context in Afghanistan, some relevant interventions are missing and these will be addressed in the next section.

6.2. What Other Elements are Missing?

The Afghan National Reproductive Health Policy and Strategy have been adapted from the WHO's SRH Guidelines. The initial task for policy makers and the RHTFs were to overlook the 'Sexual' term, and count sexual health issues under Reproductive Health. Yet no protocol is put in place to provide advocacy around sexual health. This suggests that a large number of Afghans, even at the policy-making levels avoid discussing about sexual issues. the differences between sexual and reproductive health (SRH) and only reproductive health (RH) are not clear and confuses the reader.

The Reproductive Health Directorate (RHD) plans to educate family members (elderly women or mothers-in-law) and religious leaders in terms of family planning. However, the involvement of men, particularly husbands, whose decisions in the household could have a direct impact on child spacing, is overlooked in the strategy. There are no specific family planning advocacy and counselling programs at the community and health facility levels for men.

Furthermore, it has been acknowledged in the RH Strategy that the Ministry of Justice (MoJ) could support 'breast milk substitutes and maternity leave laws' and the Ministry of Hajj and Religious Affairs (MoHRA), particularly religious leaders could support the implementation of wider RH Policy contents. However it has not explicitly mentioned that these two ministries could significantly support women's rights and child spacing, the reduction of gender-based violence and young age forced marriage.

Mental illness is a critical health issue amongst Afghans, particularly women. According to the Mental Health department of MoPH (MHD 2014), in an assessment in Takhar province 98% of pregnant women suffered from mental illness and they needed mental health services. Another survey of the southeastern zone in 2012, which included three provinces (Nangarhar, Laghman and Kunar), demonstrated a very high mental illness ratio amongst women. The statistics indicated that 65-70% of women who had access to the health facilities suffered from mental illness and over 60% of women were affected by depression (MHD 2014). This issue was further discussed in an interview with one of the MHD officers, who stated that the survey created issues and they received official warnings not to publish the report due to political reasons.

Other studies have further demonstrated the commonality of mental health issues amongst women. For instance, a national survey in 2004 indicated that depression found in 73.4% of women and 83.5% of women had symptoms of anxiety (Lopes 2004). A study in Kabul, during the same time period, indicated that 78.6% of widows suffered from depression (Care International 2004). Maternal health improvement could have a clear link with maternal health and well-being. However Maternal Mental Health is only one element amongst many crosscutting health issues in the sixth component of the RH Strategy and the MoPH has not yet developed guideline and protocols at the health facility and community levels in order to improve mental health screening and psychosocial support.

In the RH Strategy (2012-2016) that there is no research data on the number of pregnant women tested or treated for Sexually Transmitted Diseases (STDs) or Sexually Transmitted Infections (STIs). No interventions have been recommended for the prevention and detection of Sexually Transmitted Diseases, such as syphilis, gonorrhea, Hepatitis B, Chlamydia and Pelvic Inflammatory Disease (PID) for all pregnant women during ANC visit (HNN 2010). In addition, some women are at risk of being infected with HIV due to a lack of awareness around safe sex, protection and condom use (Todd 2008, NEONCP 2010).

Indeed, there is significant uncertainty around the effective implementation of RH recommendations. Capacity building training is an important element in each RH strategic component but there are no standard training packages of IEC/ BCC in the reproductive health sector. In addition, there are no specific recommendations for health officers to follow-up the knowledge transfer at the health facilities.

The RH Strategy urges the ministries (Ministry of Education, Ministry of Communication Information and Technology and Ministry of Culture and Information) to collaborate in terms of IEC/BCC implementation. Legislative action to tackle young age forced marriage has not been enforced and information about this issue is not provided to local communities. These issues are not covered in the RH policy/strategy, and guidance on these matters is not issued to health professionals.

The RH Strategy does not clearly address the enforcement of professional ethics, and accountability, and respect for patients' informed choice and privacy in health facilities (WHO/HRP. 2014, Warren 2012, Freedman & Kruk 2014, White 2011, FIGO 2014). To establish user-friendly and high standards of respectful (WHO/HRP 2014) sexual reproductive health care services and referral systems, the NRHP&S stresses the significance of higher quality of RH services. However recommendations for effective quality assurance to translate RHP&S into practice are missing. For instance there is no evidence over my data collection period to indicate that routine RH service provision e.g. ANC check-ups such as blood pressure or body weight measurements, PNC visits and childbirth services in health facilities were assessed according to the protocols. Moreover, HSPs knowledge and accountability around RH routine practice protocols and proper Monitoring and Evaluation (M&E) process are missing.

The provision of accessible diagnostic test facilities has not been addressed in the RH Strategy. Currently, there are no free diagnostic or lab facilities for the detection of pregnancy related diabetes, anaemia, STIs, TB and malaria (NEONCP 2010) in Afghanistan. Diabetic pregnant women have to visit private health facilities' to obtain dietary counselling and have blood sugar measurement tests (RHD/ MOT 2014). Moreover ultrasound or diagnostic imaging tests are not done in district and provincial health facilities (ibid).

According to the UNODC (United Nations Office on Drug and Crime) and Ministry of Counter Narcotics latest report (UNODC 2015) around 1.9 to 2.4 million adults (12.6% of the population), including women, suffer from drug addiction. The regional director of UNODC indicated that the prevalence of drug addiction among women (including pregnant women) increases day-to-day because of a lack of awareness around drug harm, particularly opium, poor access to health facilities and poverty (UNODC & MoCN 2013, Perky, 2007). The UNODC report (2015) notes that there are 123 treatment centers in the country (including eighteen for females and fifteen treatment centers for children). However these centers could only treat 10.7% of male drug addicts. There are only twenty-

one governmental harm-reduction and addiction treatment centers in the country, and the rest are supported by NGOs and private sector. In Kabul for instance, there is one governmental inpatient centre for the treatment of male drug users, which is not in a position to treat a large group of addicts (UNODC & MoCN 2013).

Substance abuse is forbidden in Islam and socially unacceptable, therefore addicted people especially women have to remain underground and socially excluded due to the social stigma and discrimination (Perky, 2007). These addicted women, in order to support their addiction, will be exposed to harm such as, violence, STIs and unintended pregnancies. Although multi-sectoral coordination was proposed in the National Drug Demand Reduction Policy (MoCN/DDRP 2012-2016) to reduce the pervasiveness of drug dependency amongst women, there are no recommended interventions in RH Strategy/Policy or any initiatives to increase people's awareness around opium and other substance use, especially during pregnancy and childbirth. In addition, there is no particular mention of action plans in the RH Strategy for the treatment of female addicts and provision of contraceptives in order to prevent unintended pregnancies.

Although the MoPH/ RHD constantly request additional funding and better coordination between donor agencies, NGOs or implementing organisations, and the private sector, there is no recommendation for sustainable RH services particularly in remote areas. In addition, the RH Strategy does not introduce any specific interventions for RHD self-reliance in an era where many funding streams for the health sector are drying up.

It is emphasised in both the RH Policy and Strategy that ministries could coordinate with MoPH in a smooth and unified environment to implement SRH Policy. However it is not distinctly mentioned that improvement in other aspects, such as poverty reduction, safe access to school (UN 2014) and health facilities, improvement of women's status at the family and social levels, provision of supplementary food for pregnant women and post childbirth mothers who suffer from malnutrition and anaemia, could have a profound impact on women's health and well being.

In summary, the RH Strategy seemed to be comprehensive in terms of its components, although, many common SRH issues have not been explicitly highlighted. It seems that the MoPH has been working on SRH reform, especially supported by WB, USAID, JICA and other organisations that are taking an overview of the whole system and identifying gaps in service provision, setting standards, etc. This technical approach to the SRH system has merit and to a certain extent will work across multiple cultures but

guidelines and targets are always interpreted in place and local/national organisations need to be included. It seems that the MoPH is seeking to super impose a system with some important implicit values that differ from the values and practices that many Afghans hold as normal acceptable and/or right. For instance, it is stated in the RH Strategy that emergency care services should be provided for complicated abortion, post abortion and situations of interpersonal violence. However abortion and post-abortion services, counselling and/or referrals for a violence victim are not offered in health facilities due to the social stigma. Moreover HSPs are reluctant to explicitly discuss family planning methods to patients because of their cultural values. Applying an overarching technical system is not going to change these values. If we want a real change in the health system and the health of women, then there has to be change in sociocultural beliefs and practices.

Chapter Seven

7. Social Factors at the Individual Level-The Life Cycle of Afghan Women

Introduction

This section explores the social factors that impact on SRH service uptake at the individual level. From the many factors and themes identified within my data analysis (See Appendix D), I distilled four high-interconnected themes: lack of knowledge about SRH, lack of communication, lack of honour and lack of trust.

Communication involves verbal, written, behavioural and non-verbal exchange of information or knowledge, which is the foundation of any relationship (Oxford 2015, SYN 2015). There have been debates over the universal improvement of SRH and more emphasis has been made over communicating SRH, which is an important element of health literacy (CSO and UNICEF 2011-12, WHO 2003a). However, it appears to be a significant challenge in countries with traditional contexts like Afghanistan to communicate about issues related to SRH. It is important to note that in this paper most quotes are from female participants because communicating with men or boys related to SRH is a taboo for a woman. Obtaining information from married women within appropriate settings is easier for a female researcher.

The scholarly literature on trust confers that trust is built when there is mutual respect and proper communication. Trust and honour are also related aspects and trust will drop when deception is seen in an individual's speech or attitude (O'Neill 2002, Savage 2015, Dulewicz 2015). Forwe (2005) in his study notes, that unfaithfulness and distrust deters even basic communication at the personal level, which can then cause interpersonal relationships to seem unreal, temporary and forced. Trust means expecting others to maintain mutual relationships and honour an individual's persona and opinion (Möllering 200, Hollins 1998, Savage 2015).

The notions of trust and honour in Afghanistan have many implications. Some people use the word 'Trust' to mean trustworthiness, or having faith or confidence in someone or

something (Glosbe 2016). Honour (in relation to women) usually means faithfulness. In the Afghan context, honour and trust are linked to the control of sexuality. Women who follow the family rules and respect social customs are well trusted and honored in the households and social context (WCLRF 2010). In other words, honour is an indicator for protection and pride for a woman in the household, but the level of trust and honour will drop for a woman who brings 'dishonour' on a family if she behaves 'inappropriately' (Transparent 2016). People who are associated with her consider her lack of honour and trust as personal insults and they can be socially demeaned just by being related to her. The loss of reputation and status is so severe that associated people can also exclude them from society (ibid).

As SRH is dependant in part on health status at the commencement of puberty (especially in the Afghan context) this chapter is structured in accordance with women's life-cycles. It also includes some illustrative life stories provided by participants who wished me to understand the context and events of their current social and health status.

7.1. Childhood

7.1.1. Girl Child Status in Afghan Household and Society

Family and society members shape the attitudes and personalities of a girl or boy from their early childhood and in some contexts these actors validate the superiority of males over females (AFGA 2012, Shannon 2012, Amin & Chandra-Mouli 2014, Fulu 2013, UNICEF 2014a). In many societies where a son is treated differently, stigma against girls starts in early childhood and both girls and boys grow up embracing unequal gender attitudes (ibid).



Photo 16. A newborn baby boy in a maternity section

There has been very little qualitative research into household members behaviour around girl-child births in the Afghan context. A research report by the 'Women and Children Legal Research Foundation' (WCLRF 2009) with financial support from 'Save the Children' of Sweden-Norway uncovered the realities that discrimination against girl-children exist within the Afghan households and society. It is discussed that a girl-child is viewed as a liability and burden in the Afghan society (ibid). As a result a large number of Afghan families do not celebrate the birth of a girl. However if it is a boy-child, parents and family members will usually celebrate the birth of their son by inviting relatives and friends to a lavish party, which usually lasts all day (ibid). The celebration expresses gratefulness for God's blessings. According to Islamic teachings (Prophet Mohammad BPH Sunnah) the celebration is called 'Aqiqah' and usually parents sacrifice a lamb and distribute its meat to

neighbours and needy people (AFGA 2012). In addition, a large proportion of parents invite their relatives, name their son and cut his hair on the sixth day of his birth (Ibid).

A survey of school-aged children by Panter-Brick (2009) identified a two-fold greater risk of psychiatric disorder and depression amongst girls than boys due to their exposure to traumatic events and violence (severe beatings) in the Afghan household. It is also noted in the Afghan context that acts of violence against children go unnoticed and are considered an acceptable form of punishment and control (ibid). Another piece of research into school-age children in 62 countries by UNICEF (2014b) reports that children face various types of discrimination and violence as a result of parents and other family members anger or frustration.

My research findings also indicate that there are exceptions. A small number of my research participants had a good childhood and the right to go to school. I provide an example of Donya* (4) a charming lady from Kabul whom I met in ASB/DH. She was five months pregnant. I found that she had good memories of her childhood,

“I have three brothers and one young sister. I grew up in a family where I did not even have a pinch. My parents call me lovely, sweetie and dear. I have sweet memories of my childhood. With the birth of every child in my home my parents had a celebration. My parents celebrate my sister, brothers and my birthday. Even before my marriage my parents celebrated my birthday. My grandmother has given (Donya) name to me and my father was calling me a baby doll. My mother did not allow me to get to school without having breakfast. When I was coming from school my mother was saying “oh my lovely daughter is tired” and she used to cook my favourite dishes.”

Donya was one of those lucky girls who enjoyed her childhood and reported that has never been exposed to discrimination during her childhood. Some other participants reported similar positive childhoods. A significant number of women noted that they however, did not have a pleasant childhood. They also mentioned that their husbands and other household members do not honour their girl-children. We now consider an example of Razia (312), a young woman who shared her childhood story, which indicates that she was deprived of childhood pleasure and happiness, in part because of poverty.

* Participants' names are pseudonyms

“We used to live in my grandparents house. We were 4 sisters and one brother and we all used to sleep in one room with my parents. My grandmother did not like us and was always abusing my mother. I did not know why she was angry with my mother and never talked properly with my sisters and I. Now I know, she was upset because my mother was giving birth to girls. My grandfather liked my elder brother and he used to allow him in his room. He used to buy him good clothes and shoes. My father admitted my brother to a school in the city and my grandfather was paying his school expenses. My grandfather bought a nice backpack for my brother on his birthday and I remember that I really liked the bag. I cried a lot and wanted to have one. My father admitted us to a local school because he could not afford our transportation expenses. We did not have a school bag and we used to tie our books together with an elastic band and walk to school.”

I asked her if she has received any birthday gifts from her grandparents or parents. She paused with a bitter smile. I felt she was hiding a great grief inside her.

She said: “oh my parents did not know my birthday. They just knew which season of the year my sisters and I were born. My mother said she remembered that it was snowing when she delivered me but she forgot the month and day of my birth.”

“I used to get pneumonia a lot. We were poor. If we were ill my mother would bring one of us to the health clinic and then she was giving medicine to all of us. Sometimes my aunt (father’s sister) massaged my throat or my mother put plastic on my chest after rubbing Vaseline so that could stop my cough and I felt warm. My aunt (my uncle’s wife) had a good life condition and she used to give us her children’s old clothes and shoes. I never minded wearing their clothes and shoes. However sometimes our class fellows were making fun of us because my sisters and I used to wear shoes different from our sizes. Can you see my foot (I could see her feet had bumps and abnormal shape) it is all because I wore shoes different from my foot size. What could I do? There was no option!

Every morning, without having breakfast we (my sisters) used to go to school. In our class break, we did not have any money to purchase anything from the school canteen. When my class fellow was asking me about eating something I said that I had had breakfast and I was full. I was only thinking that when I go home I will eat lunch. However coming back home my mom waited for my brother to take some money from my father to buy some groceries for cooking lunch. My father used to work in my grandfather’s shop and my mother was waiting for my brother to bring some bread, onions, eggs and cooking oil.”

I asked her: "Did you eat omelet everyday?" She started laughing! She said:

"Huh! My mother used to make eggs gravy so that be sufficient for all of us. We were eating bread from hunger before my mother was cooking the eggs gravy. Then my mother was mad with us for eating bread. She was telling, at least we could have waited until food was ready. We could hardly have rice. Sometimes my mother used to cook rice and kept it for my brother. We were not allowed to eat his portion.

At home my elder brother used to give names for us. He used to call my elder sister "sya gak" (dark skin). I was called "Manai" (apple cheeks), my third sister was entitled as "Kandoo" (big tummy) and my forth sister was "chob e dolak" (drum stick). Every time we were fighting we used to abuse each other with these given names. I remember my mother was pregnant again and again and we had two more sisters. She was busy with the house chores and serving my grandparents. My father was coming home late evening and he never knew about our studies and never wanted to talk to us. Neither my father nor my mother helped us with our studies. When at night we were studying my mother used to shout to keep us quiet because my father was tired. We could not talk or laugh loudly. Sometimes we could not control talking or laughing out loud. Then we had to bear my father or mother's bad words or beating. I have no idea how we pass and finish our school successfully without anyone's help.

During my late childhood my mother sent my sister and me to my Uncle's home to help his wife with children and house chores. I did not want to go there. They used to ask me to take my cousins to the toilet and clean them. In short basically my sister and I were there as servants. Maybe my mother wanted to at least get rid of us because of their financial constraints, or she might have been fed up with our fighting. My brother used to beat us a lot. However she could not imagine the level of insults that we were facing in my uncle's home. My uncle's wife was calling us as "insects children." Finally one day my parents came to my uncle's home and saw me dirty with very old clothes. My uncle's wife asked me to bring my cousin to the toilet. My father told them that we were needed to help my mother with chores and brought us back home."

Not only Razia, but also many other research participants of this research did not know their actual dates of birth because their births were not celebrated or registered. Razia's deprivation of childhood pleasure, being called by other names and not being loved by parents and grandparents, illustrates what often happens where a son is preferred over girls in poor families. In the same way, Nikki van der Gaag in her report of 'The State of the

World's Girls' (2008) indicates that the status of girls' in many countries is lower than boys and they are not usually valued. Razia's story about her and her sisters not having direct communication with their father was common among my participants. It seems that her mother conveyed her father's messages to them.

Despite the deprivation Razia and her sisters still attended school, unlike a large number of women who stated during interviews that due to economic constraints, insecurity and some social beliefs, they did not go to school or had to drop out of primary school and get married. These findings are comparable to the WCLRF (2009) report on girls' education. WCLRF interviews with 800 Afghan parents found that 22% did not allow their daughters to go to school due to insecurity, 16% due to poverty, around 13% due to indecent social customs and the 15% of women respondents mentioned that they used to educate their daughters even though their husbands did believe in not allowing girls to go to school. The report stated that 42% of male respondents (mainly from rural areas) were against girls' education and they perceived that it would damage their honour to allow girls out of the house. The same report noted, a total number of 73 registered cases of sexual harassment of girls by a male relative, by neighbour boy or street boys. According to this and other reports (AIHRC 2015a, Moore 2011) sexual harassment in Afghanistan is a normalised practice and this could be one major reason for girls to be kept at home.

A total of thirteen research participants mentioned that they were engaged from early childhood and had to help their mothers with household chores instead of attending school. Amongst these participants, I only found two women who in spite of being engaged in their early childhood, attended school with their family support. Zarmina (32) is one of these women. She is a nurse and mother of three children. I used to sit with her in ANC/PNC room in a Comprehensive Health Clinic (CHC) and observe her and patients. One day during lunch break she said:

"You interviewed many women and listened to them. If you listen to my life story you will learn about the conditions of my life. She said: "I am telling you about my childhood engagement to my cousin."

She seemed unhappy about her early childhood engagement to her cousin.

"Uff (Alas!) In Afghanistan, if a girl is engaged in childhood she has to marry that man, even if she does not like him. They do not listen to you and make a nonsense cause that she is our pride and honour and we have to marry her. My family was good and bad. They

engaged me in my childhood without asking my opinion but allowed me to study. After knowing that I was engaged in early childhood, I cried a lot, I even fainted. No body cared about my health and they said, “she is just acting.” Only one thing is good that my mother did. She insisted my uncle let me finish my studies. I later was able to study two years of nursing. I was quite young when I was married. I felt so stupid to accept all the pain and responsibilities for the sake of my family name and honour. If I would have had half of the intelligence that I have now, I would never have married him.”

Engagement in early childhood is considered one of the factors that hinder young girls access to education and discriminates against her rights. In other words, early childhood engagement means the girl loses the chance to decide about her own future life (WCLRF 2009).

Parents shape their children’s personalities and their human capacities are strengthened by education. The family environment is the first training centre for children, where parents can have a profound influence on children’s behaviour and attitude through building emotional relationships (AFGA 2012). The above life stories depict a common theme of girls growing up with a lack of honour, love, attention and unmet needs.

A study of WCLRF (2009) reported that 44.8% of the girl participants mentioned that their parents beat them. Likewise, my research findings indicate that 150 women participants had experience of similar issues as Razia and her sisters faced. They experienced harsh and abusive behaviour by their family members, including their parents, during childhood.

In summary, the girl-child is frequently treated differently to boys in the Afghan context. The foremost reasons that prevent girls enjoying their childhood are poverty, insecurity, social beliefs honour and family dignity. Economic constraints also hinder family access to health care services. Girls may lose their identities by being called belittling names in the household. Girls grow-up without the freedom to discuss major life events.

The next section explores girls’ life through adolescence and the factors that impact on SRH knowledge and service uptake.

7.2. Adolescence

7.2.1. Puberty

- Communication and Knowledge of SRH

The research findings reveal that in many Afghan ethnic groups, talking about sexuality, changes in adolescents (10-19 years of age) body organs, menstruation, nocturnal emission, STIs and marriage are forbidden in the family and social milieu. A significant number of research participants shared their experiences of poor communication with their parents about sexuality and their consequent ignorance of such matters. Afghan girls might not dare to share their concerns about puberty, obtain information from other sources or even ask for sanitary pads. Let's know more about Razia's* (312) adolescence.

"When I first developed my breasts, it was summer. In the afternoon everyone was sleeping because of heat and long days. One day, I found my mother sleeping in the shadow of the apple trees in our garden. I went and slept next to my mother and told her. Shall I ask you something? She replied, ha quickly. I said, "why do women have breasts." She said "Dokhtar bi chishm ee chi sawal ast ke mikoni?" meaning "you are a very cheeky girl and what question is that?"

"My mother warned me that I should never talk like this. I felt very ashamed. I was blaming myself why did I ask this. I was thinking if my mother tells to my other sister then they would laugh at me. That impression remained in my mind and I never had the courage to tell my mother about my menstruation or tell her to buy me bra. I used wear something underneath and did not walk straight so no one could see the bulge."

"I had my periods when I was 11 years old. I heard from my class fellow that she had her menstruation. I was thinking that why I did not have it. I was scared and being a little bit nervous about having my periods. When I had it, I could not tell my mother. I cut my old blouse and used it as my sanitary pad. I did not know how to use that piece of cloth. I had to hide the piece of cloth in the storeroom. I waited for darkness. I was washing my piece of bloody cloth after washing the dinner dishes. I had to check that no one went to the toilet when I was taking the bloody piece of cloth and was washing it. To dry it, I was putting it under the bedspread so no one could see that piece of cloth with bloodstains. I remember because I had to fold the clean part of the cloth and use it for so many days. My thighs were sore due to

* Participants' names are pseudonyms

the dried blood and when I was washing, it was hard to remove the stain of dried blood and I was suffering from sore hands too. I was feeling shy when my mother was asking, "Whose piece of cloth is in the storeroom? Remove it from there if your father sees it would be bad." I was blushing and could not tell that I put it there. I had been itching after menstruation, but I could not tell anyone."

We learnt that Razia had a non-communicative relationship with her parents. She learnt about menstruation from her classmates but was misinformed on this issue. She could not find out the correct information from her mother although she had tried once to ask her about her changing body. As Razia had lost self-confidence in childhood, on reaching to puberty she could not share her queries and concerns with her mother or sisters, which resulted in suffering. She would have developed an infection due to the use of unhygienic cloths during her menstruation. A total of 130 women, during interviews and focus group discussions, described similar experiences about being unable to ask or receive information about body changes in puberty, even with the parent of the same sex. It is regarded as shameful to discuss such issues with family members.

Those who do talk about SRH issues confront misunderstandings and embarrassment. I met Shafiq* (19) a Pashton woman who at the age of 22 was mother of 5 children. Shafiq* was very lively and shared her first experience of menstruation. Her story was funny but at the same time was very sad.

"I have seen my mother in pain while delivering a baby. She went to the 'Kenar aab' (local unhygienic toilet) for childbirth. However I did not see how she delivered the baby. I had so many questions in my mind. At first, I did not know how a baby was born. After I saw my mother bleeding and having pain I got to know that she delivers her baby from that lower part. I was 12 years old when I had terrible pain in my back and I saw blood in my knickers. After I saw my bleeding is increased, I run towards 'kenar aab' (local toilet) and sat for hours. I could see blood but nothing happened. My mother shouted at me "why did you spend two hours in the toilet?" I was reluctant to tell her that I was bleeding and will deliver a baby! My mother came and pushed the toilet door. She said, "Why have you spent a long time here. Go out, you need to do some house chores." I started crying. "Mother there is blood 'ushtok namibraya' (the baby does not come out). My mother got angry and asked me to open the door. I opened the door while she saw blood on my thighs and knickers, she said, "Stupid! It is menstruation. All girls will have. It is not childbirth. Ohhh! Huhah" you know I was embarrassed and upset that I did not know all about it. If my mother had not come to the toilet, I would have spent hours expecting a childbirth, hahaha."

Girls are physically close to mothers as they usually spend most of their time supporting their mothers doing household chores. However they are not communicating issues regarding bodily changes during puberty and pregnancy. Razia and Shafiqā's stories show that a non-communicative relationship between mother and daughter about puberty leaves adverse impressions on adolescents' minds and causes them to feel uncomfortable, hide personal changes and remain unaware of menstrual hygiene (UNFPA/RHIYA 2007).

In my research 20 mothers in law, 11 mothers and 103 other female participants reported that they avoid talking to their daughters or answering to their queries. A mother (21) who was an educated woman admitted her shame about educating her children about puberty and reproduction. She was a mother of 7 children. She had 4 daughters and 3 sons.

"When my daughters ask questions like how a child is born or why do women have breasts, we never answer it. We do not ask our children to consider hygiene in intimate body part. Due to the shame we never address these issues. We do not speak about it, because we grow up in the same situation where our mothers never told these things to us."

The quote depicts that ignorance and stigma about puberty and reproduction is passed from generation to generation. During participant observation in one of the Kabul districts' Comprehensive Clinics a mother and her daughter (313,314) entered the women section of the clinic and asked to see the female doctor. Unfortunately the doctor was not in her room so she entered the antenatal room where the midwife was examining pregnant women. She told the midwife:

"Please check my daughter (she was probably 11 years old). It has been so many days that she goes to the toilet and cries."

Midwife (MW): why does she cry?

Mother: I do not know. She says, "I cannot pee."

MW: Did you see what is wrong?

Mother: Nooo. She does not allow me to see.

MW: Come here."

The girl reluctantly walked towards the midwife who said:

"Lie on the examination table."

At first, she did not allow the midwife to examine her. After 5 minutes of talking to her she finally allowed the midwife to examine her. The midwife was shocked to see how swollen her vagina was and how much discharge she had. She found toilet paper in the girl's vagina (in order to absorb her discharges and avoid getting wet pants).

MW: "Wiiii! (In a harsh way expressing her wonder and make mother embarrassed) What sort of a mother you are? At least you could have taught your daughter to wear knickers and wash her intimate parts properly."

Mother: "Hmm. So what should I say? This girl herself does not tell me anything. You know better than me, tell me what should I teach her?"

MW: "When did this problem start?"

Girl: "I do not know. After menstruation I have itching. My pants get soaked with some dirt comes out of here (vagina)."

MW: "How many times do you change the sanitary pad?"

Girls: "I use a piece of cloth for two days."

MW: "Do you iron or put the piece of cloth in the sunlight after washing?"

Girl: "No."

Mother: "Nooo. She feels shy. She hides from everyone. I never know when she has her periods."

MW: "Due to some microbes she was itching her private parts and that area became sore. Now she feels burning and cannot pee. At least you could ask to wash her private parts with water properly. Put the pieces of your sanitary clothing in direct sunshine or iron them. Give her some knickers so she avoids using toilet paper. Toilets paper itself causes irritation."

The conversation suggests that neither midwife nor the mother addressed the girl directly. Their conversations were all about the girl's health but neither instructed her and clearly advised her how to improve her health. For me there were unanswered questions about the mother's behaviour. Was this a lack of knowledge by the mother, or was it just a taboo to talk about it, or a combination of both?

From the participant observation and interviews with HSPs, it is common that mothers' avoidance of discussing issues related to womanhood causes many adolescents to suffer with RH issues. They bear the pain silently. The daughter in the quote was fortunate that her mother took her to the health facility for treatment. In a focus group discussion in one of the district hospitals, two female HSPs (281,282) were discussing the reasons mothers do not discuss issues related to body changes, menstruation and sexuality.

(281): "I have a 9 years old daughter and I cannot explain everything to her because I think she might not know about it. If I inform her about menstruation, changes in her body or pregnancy she might get interested about the issues and know more than her age."

(282): "Until her friend tells her or she experiences something wrong, it would be better if parents talk to their children. If parents explain everything to their children before they get some inaccurate messages from outside, it is better for the child's future and awareness. My friend was telling me that I am blessed to have knowledge of these things and I do not hesitate to share my experiences with my children."

The discussion indicated that not all mothers think keeping their daughters in ignorance in a good thing. A woman of Tajik ethnicity (161) shared a similar opinion during an interview in one of the governmental offices. She works as a health officer and provides health education to people.

"I was ignorant about sexuality because my mother never told me about it. She believed I should learn everything after getting married because I was a woman. I said to my daughter that when you reach puberty you will face many changes in your body. Now she goes to medical university and learns everything practically. If I tried to withhold sexuality information she would do many things without my knowledge or would receive incorrect information from others. The need for understanding about sexuality and reproductive health starts in childhood and it is parents' duty to provide appropriate information to their children."

She believes communicating SRH issues with her daughter provokes her daughter to talk openly with her mother and enter society confidently and knowledgably. The above quotes suggest that Afghan parents often believe that the best time for their children to learn about SRH is when they marry and have children. To tackle widespread social sensitivity around discussing SRH issues, and poor communication between parents and adolescents, some organisations provide SRH awareness programs. One NGO has worked for over 50 years in

Afghanistan and introduced a telephone-based youth health awareness project in Kabul city. This awareness program was a pilot project to observe the responses of youths, especially educated adolescents, to SRH awareness programs. After eliciting a positive response from the youths, the senior staffs planned to expand the project to 4 big cities in Afghanistan by the year 2016. SRH counselors in the pilot received 100-120 phone calls per day. Females usually report ignorance about menstruation, wedding nights and intercourse. Some engaged girls, shocked by the grooms' romantic behaviour, share their concerns and feelings of guilt. The sexual reproductive health counsellor employed by this service (212) said:

“Many girls who want to know about sexuality feel shy and do not possess the courage to find out about foreplay, intercourse or any sexual behaviour. However they themselves call us and want to know about it. We receive phone calls from people who have questions around: sexual relations, masturbation, the wedding night, and the anatomical structure of the vagina and penis. Some girls who are forcefully married or engaged at a very young age feel upset because their parents do not want them to go to school and they seek our opinion. Boys usually are keen to know about girls' menstruation, low libido and low levels of arousal among women.”

My research data shows that such ignorance is widespread. Social norms and stigma create a family environment in which parents do not discuss issues related to sexuality or bodily changes to adolescents. Mothers and especially fathers rarely communicate about SRH issues (It is way beyond anyone's expectation to see a daughter share her concerns with her father).

Although, this section has demonstrated adolescents' curiosity and desire to understand the changes in their bodies, for the majority of my participants, these needs were not met. As a consequence many people entered marriage without proper SRH knowledge.

7.2.2. Marriage

Marriage based on mutual trust, honour, understanding and future commitments between man and woman can bring about positive mental well-being (AFGA 2012, WCLRF 2010). It is widely known that in various cultures, couples usually start a new life with the aim of cohabitation and reproduction (Schwimmer 2003). Islamic teachings refer to marriage as meeting the legitimate biological needs of humans for sexual relations and offspring (Ibid).

The pattern of young age marriage is widespread in Africa and South Asia, Middle East and parts of Latin America and Eastern Europe (UNICEF 2014a, Ahmed 1997, Heise 1999). In the Afghan context, arranged young marriage is common practice amongst all ethnic groups (WCLRF 2008, 2010). The parents typically are the sole decision-makers in arranging the marriages of their sons and daughters. There are infrequent reports of a girl and boy selecting their own marriage patterns (Amnesty International 2008, UNIFEM 2008b, ICRW 2004, WCLRF & OSI 2010, Raj & Charlemagne 2012).

Referring back to what we discussed in the 'Research Ethical and Feasibility Issues' (Chapter 2, Section 9), the marriage of a girl under the age of 15 is not considered legal by Afghan Civil Law (1977). Under the Afghan Civil Law and CSO (Central Statistical Office), the legal age of marriage for girls is 16 and 18 for boys (CSO 2011-12, WCLRF & FF 2008). The pattern of the actual age of marriage in Afghanistan remains unknown, because many people do not register their marriage certificates in the court (CSO 2011-12, MPI 2005). However a study by WCLRF demonstrated that a larger proportion of parents from diverse ethnic groups particularly Tajik and Pashtons, marry off their daughters when they reach puberty (WCLRF 2008, 2010). This is serious concern because early age marriage increases the chances of death from childbirth and disabilities because of young girl's apparent vulnerability to numerous health issues such as obstetric fistula, RTIs or STIs (Chandra-Mouli 2015, UNFPA / RHIYA 2007, Miller & Kotchick 1998, Shaw 2009, Egmond 2004, Santhya 2011, Raj & Charlemagne 2012).

Similar studies by UNICEF (2008) and Behgam & Mukhtar (2004) determine that around 57% of Afghan girls were forced to marry under the age of 18. According to my data, and general knowledge, in a significant number of Afghan families, particularly in rural areas, when a girl reaches puberty, parents' start looking for a groom and arranging her marriage, and those Afghan families who would like to marry off their sons also seek younger girls. UNICEF (2008) report that these young age marriages of Afghan girls are associated with poor health status. Within my sample of 390 female participants, 131 women were married under the age of 15,

140 participants assumed that they got married between the ages of 16-25 and 65 women did not remember or mention their age of marriage. Of these only 4 participants stated that both they and their partners decided to marry of their own free will.

Since a large proportion of childbirths are not registered a great number of women do not know their true age. These participants usually guess their age of marriage from the number of children they have and their first menstruation. Exploring the core values of marriage within the Afghan household and communities is crucial in terms of the women's life cycle and its significance in SRH seeking behaviour.

Perceptions of an arranged marriage might vary according to their socio-cultural beliefs, political and economic aspects and needs. According to a large proportion of Afghans, marriage increases the value and honour of girls in the eyes of her household, in-laws and community (AFGA 2012, WCLRF & OSI 2010, UNIFEM 2008b). It is believed in the Afghan society and households that a girl after menstruation is mature enough to be married and have children. A male health provider (259) who reinforced this perception stated it even more bluntly.

“People say: “hit the girl with a hat. If she does not fall, then she is prepared for marriage.”

This expression demonstrates that if a girl is strong physically, she can be married irrespective of her age. But it is not only girls who have no say in their choice of the marital partner. A male psychosocial counselor (237) during an interview discussed how young boys also complain about the lack of communication within family and especially with parents, including around marriage. He added:

“While boys want to marry a girl, most of them do not have the courage to discuss it with their parents. Even if some boys talk about the girl of their choice, their parents never value their choice, and arrange their marriage with someone else. This condition increases the distance of sons from parents, and causes feelings of hatred in the newly married man towards his parents and wife. This condition leads to various types of violence.”

In such circumstances it is not surprising that the desires of newly married girls are disrespected. A significant number of female research participants mentioned that they wanted to get married after completion of their education but their perspectives were not valued. This devaluing of women and their dreams is deeply entrenched within families and the male household members' decisions about the marriage of a daughter must be respected by other

family members (WCLRF & OSI 2010). This devaluing of women is also passed from generation to generation and influences other decisions about daughters' life options. Many parents during interviews expressed their views that their daughter should learn to do household chores and serve her parents, and after marriage serve her in-laws and husband. Less importance is placed on girls' literacy. For instance, Hakim*, Lailoma's husband (2,3) during an interview stated that he is the only decision maker in the household. He clearly shared the reason for not allowing their daughters to go to school and marrying them off at a young age.

"If my sons want to study I do not stop them, but it is our family custom that we do not let women or girls go to school and study. Girls' jobs are to learn household chores and after marriage take care of her in-laws and husband. I do not like girls going to school. It is a shame. If the man of the household says something, women should know that there are some advantages behind the decision. We do not permit our women go outside the house until they are married. As I obeyed my parents, my sons and daughters have to obey my desires and decisions."

According to this male participant, it is not acceptable in his tribe (Quraish) for women to leave the house before marriage. In this way, parents ensure that their daughters learn household chores before marriage. My data shows that women from such tribes accept this as a natural part of their life course.

During an interview with two Pashton sisters (37, 76), they discussed their marriage at very young ages and their lack of schooling.

I asked: How old were you when you got married?

S1: "I was 12 years old when I got engaged and the next year I was married to a man who is 20 years older than me."

S2: "I was 10 years old when I had my menstruation and I got engaged and within a year, I got married."

I asked: Why did you get married? Why didn't you tell your parents that you want to study?

Both girls laughed and replied:

* Participants' names are pseudonyms

“We are Pashton. It is not within our customs to study. We just studied Islamic lessons with Mullah. My father did not let us attend school. It is a shame if a girl goes out of the house and studies. When we became young (meant to say after having first menstruation), our father did not want us to stay in our parents’ house. After our menstruation my father was telling to my mother “Wina pa me ragerzi” means every month of my daughters’ menstruation is similar to the murder of someone.”

I asked how her father knew that she reached puberty? The girls replied with a smile:

“My mother tells him. Then anyone who is rich or can afford to pay the cost of marriage ceremony and bride price would propose.”

To find out more about why parents marry off their daughters at a very young age without their consent, (some daughters even do not know whom are they being married to), I sought religious leaders views according to Islamic law during a focus group discussion one Imam (374) said:

“Young age marriage is totally accepted. Even if a girl is very young and in the age of breast-feeding, parents can marry her to someone. Because it is stated that ‘Kof’ (good place of marriage) for a girl is not always available. No one can be as compassionate as her father or grandfather. However, if a father marries his daughter simply for his own benefits, then it is prohibited.”

Another Imam (371) added: *“I married my daughter at the age of nine. That was excellent.”*

A different Imam (254) said: *“Forced marriage is not supported by Islam.”* He also claims: *“Parents have the rights to marry a young girl before puberty. If an uncle or some other relative marries her by force, then after reaching 18 years old, she has the right to refuse or accept her husband.”*

Participants, who were married at a young age without schooling, were usually economically dependent on their husbands. In such circumstances, it is highly unlikely that these women would reject their husbands and ask for a divorce. Afghan women are strongly encouraged to tolerate married life and maintain family honour and values. So, even if she was aware of this religious teaching, in the Afghan society divorce is not an accepted custom. A quote from another Imam (378) suggested it is unlikely that girls who are uneducated will know about their rights to divorce.

“It means girls remain uneducated and they even do not know the Islamic rules and rights for women. If a woman does not know Islamic rules, and the rights of a husband and wife, there will be chances of various mis-communications. In Islam ‘please accept my apology’ a man can smell the mouth and underarm of a woman and then chose her as his wife. This much we have space for husband and wife in our religion. However no such thing is practiced in Afghanistan.”

In a response to questions about whether girls’ should give their consent to marry, he (378) said:

“It is a very good thing if a woman and man sit and meet before marriage. According to Prophet Mohammad (PBH), this will increase love and affection in the future. But we without girls’ agreement accept her representative’s opinion and tie their knot ‘Nekah’. Usually the girl is not aware about her marriage and we marry her. She might not have seen her husband before. Sometimes when I am invited to marriages, I usually ask the parents “have you chosen the representative of her choice?”

Despite nominal agreement to older age marriage by consent, these Imams do not actually practice this. In contrast to the Imams, some families do challenge young age marriage and lack of schooling, attempt to inform adolescents about SRH, seek their son and daughters’ agreement for marriage, and communicate about their future lives. For instance, a Transitional Justice Assistant (253) who graduated from the theology faculty, appeared to be very satisfied with her relationship with parents. She said:

“All members of my family are educated and they have a good knowledge of Islamic teaching. When I wanted to marry I wanted to see the boy before finalizing anything. We have to complete our education and then marry. In the presence of family members, girl and boy can see each other before getting engaged. There are some broad-minded people regardless of socio-cultural beliefs. They try to keep a bond with their children and encourage them to practice forbearance in the husband’s home.”

There were a few research participants who never wanted to impose their experience of marriage on their daughters. They believed that seeking their children’s agreement on marriage is crucial. A woman (173) who got married while she was only 10 years old mentioned that she cried a lot but her parents did not value her views. She added that she

and her husband decided not to force their daughters to marry a strange person in the future.

“My husband discusses how friendly husbands and wives should be. Since I did not study, my husband and I decided that our daughter should complete her education and we would ask her if she agrees to get married. He said that he would never force our daughter to marry someone that she does not even know.”

Such comments were more common amongst Hazara and some Tajiks ethnicities regardless of their educational background. My data shows that however a large proportion of the Pashton ethnic group appears to be very strict and prefers arranging young age inter familial or inter ancestral marriage instead of risking marriages with other ethnicities.

Considering the issue of young age marriage it is important to know more about the reasons for young age marriage and types of marriage in the Afghan context.

7.2.3. Social Practices of Marriage: Honour for Women or Economic Necessity

In the Afghan context, marriage is not just a union between man and woman. It is a union of two households that not only considers sexual needs but also economic aspects (WCLRF & FFF 2008). This takes various forms. Some parents demand a bride price or exorbitant expenses before allowing their daughter to leave their parents home. Other parents ‘Badal’ means exchange of the brides to lower economic settlements (each family gives the other family a girl and two marriages take place) (WCLRF & FFF 2008). Another form of marriage is known as ‘Bad’. In this form, male members of the household who committed a crime during community assembly gives female member of the household (usually a young girl) to the other party in a feud to settle the offense (Gandhara 2015, WCLRF&HBF 2004). In essence in many forms of marriage girls are objectified as a source of contentment (WCLRF & OSI 2010, Santhya 2011, Raj & McDougal 2015).

The acceptance of ‘Bride price’ is commonly accepted in many countries (Harris 2012, Schlecht 2013, CW/EFM 2013). Although, all Afghans share this social practice it is called in different names by diverse ethnic groups. For instance, research findings indicate that Pashtons call this social practice ‘Walwar’, Tajiks call it ‘Toyana’ or ‘Haq e Shir’ and Hazara call it ‘Gala’. There is a debate about such practices mean a girl is sold as a commodity to serve her husband and in-laws, or whether a bride price increases the

honour of the newly married girl (Svanemyr 2015, Jain & Kurz. 2007, WCLRF & OSI 2010, AFGA 2012). Many others believe that it boosts the financial status of bride's parents and it increases honour, trust, responsiveness and support between two families, rather than the bride herself (WCLRF 2008, 2013 and WCLRF & OSI 2010).

A total of 55 female participants' fathers obtained 'Bride price'. However 11 participants were exchanged 'Badal' in order to avert the cost of marriage, four participants were given for 'Bad' and the rest of participants did not mention the type of their marriage. Since Afghans generally believe that parents choose a marriage pattern based on knowledge, envisioning and preferring better future for their children, it was important to explore the perceptions of women who were married in such circumstances particularly in relation to the impact of 'Bride price' on her autonomy of choice to have children and/ or seek health services.

A significant number of participants expressed their concerns over the large amounts of money paid as bride price and the negative consequences that they confronted after marriage. This was especially evident during my observations in the Human Rights office (I attended IHRC primarily to understand what services they offer for women. Whilst, there I had the opportunity to observe women who approached them for help. This means in some ways my observation sample was slightly skewed towards women who experienced violence).

A woman of Hazara ethnicity (433), was forced to get engaged at the age of 15 and was married at age 18 to a man who paid the bride-price (roughly £5500) to her father. Since she did not like her husband she refused to have sex and subsequently was beaten up. Her husband did not trust her and called her unfaithful. This lady wanted a divorce but her husband refused. He claimed all the money back that he had spent from the first day of engagement to the wedding. Her parents did not want to give the money back and supported the son in-law. Her father told her husband that however he behaved with her, they would support him. Her father said: "She is her husband's property."

Several other examples similar to the above demonstrate the consequences of the social practices of marriage on women's health and well-being. Many research participants indicated that they not only lose their value and honour in the household but they are also mistrusted, ill-treated and tortured. Despite this some women still believe that the bride-price is a tradition and should be practiced to increase newly married girl's honour. The

holding of such seemingly contradictory views is well illustrated in my interview with. Friba* is a Tajik woman (184). She was admitted to the maternity section of ASB/DH after complications with her 13th childbirth. She lost her baby after a caesarean section but she was lively and started to talk about her life. She was 'Badal' (exchanged) at the age of 12. After her menstruation at the age of 14, she became pregnant and quickly had one child after another.

"My brother was older than me. My father married him with a girl and exchanged me in order to prevent the expenses of marriage. Badal is very bad. I suffered a lot. We had a farm and I used to milk cows. I was working hard and I was getting pregnant one after another. No one allowed me to go to the doctor and to take some medicine to prevent pregnancy. My in-laws and husband never respected me. Even now my husband does not admire me. Men never care and feel our pain. I think "ba zar begirin ya halal konin"(an expression which means to marry a girl by offering gold or money or kill her otherwise). My husband says if a girl becomes educated so what? Nothing will change. It is preferable that she remains at home with honour and dignity. My daughter is young and she is engaged. I obtained 1.5 lacks (around £1500) bride price for my elder daughter. This is our tradition. If you ask for money, your daughter's honour and value will be increased."

"I demanded for 2.5 lacks (around £2500) from the family who proposed to my second daughter. Her father says "it will be a sin to demand this much money" But I said, the more money we obtain the more the value and honour of our daughter will increase among our relatives and her in-laws. Her father says if the groom cannot afford and only gives me 1.5 lacks, honestly and humbly. I will accept it. This is our tradition. If parents do not ask for a 'bride price' then people may say bad things about it. They might say that the girl fell in love with the boy, or she was pregnant, or something was wrong because parents did not ask for 'Walwar' (bride price) and just give their daughter's hand to a man. When parents ask the money then people say the girl has married with honour. My sister is insisting on my third daughter's hand (means she proposed her for her son). She says I could pay more money than you received from your first and second daughters. Her son is a very nice boy. He said, if she is engaged then register her for tailoring course."

It can be deduced from the above quote that this father married his daughters on a young age both to prevent the possibility he might lose honour and trust among their relatives and to boost his daughters' honour. Friba dislikes 'Badal' because both families do not pay the

* Participants' names are pseudonyms

bride price. She believes that demanding 'bride price' could guarantee the honour and well-being of her daughters and presumably her own at the same time. Her husband believes that girls are born to serve their parents and then in-laws and husband. A substantial number of participants stated that a girl would not be honoured in her in-laws household if she is exchanged (Badal), given as 'Bad' or if parents do not ask or receive the 'bride price'. These participants' perceptions indicate that girls during childhood and puberty have to set their minds to learning house chores and look after the children because that is their only destiny.

However during my fieldwork I also came across a number of women who were happily married after 'Badal' being exchanged or after their fathers obtained a bride price. For instance, a Pashton woman (55), during an interview in the maternity section after her 5th childbirth said:

"I was 13 years old. I was 'Badal' exchanged with my brothers' wife. No one asked about my desire for marriage. I had my first baby after two years of my marriage. I have no problems with my married life. My husband and in-laws respect me. If women do not complain about home issues to their husbands there won't be any problems. If anything happens between my mother-in-law and my sisters in-law and I, we never involve men. Walwar is a custom and men have to pay before marriage, but I am happy because I have a caring husband."

She had a very positive vision about her married life. Although, she was young it seemed that she had gained much good life experiences and understood how to deal with the bad circumstances of her life.

Some female participants mentioned that social practices of marriage are related to their religious beliefs. To understand whether 'bride price' or other social practices are linked to Islamic teaching, during the focus group discussion with Islamic clerics, they were asked: Is the bride price mentioned in Islamic teaching? What if a father wants money for his own expenses?

One Imam (371) said: "There are two things and should not be combined. One is 'Mahr', which should not be less than 10 Afs (few pence), and it can be over millions. The 'Mahr' guarantees a bride's future financial status if she is divorced. Extra money (bride price) that father demands before marriage of his daughter for his own profit is unlawful. It is in some cultural practices but not in Islamic teaching."

Another Imam (258) was less clear about the legality of 'bride price' in Islam.

"In Holy Quran it is stated that what are the man's rights and are they the same as the woman's rights? How can we implement? These issues should be addressed through education and schools. 'Haq mahr' (bride price) is mentioned in the Holy Quran many times and in Hadith (sayings of the Prophet Muhammad). God says that money should be given to the bride's hand. Mahr should be paid to the bride particularly when she is divorced. Unfortunately people do not apply it in their actual life and they also exchange (Badal) or give a girl in 'Bad'."

The research assistant asked: what do you think about those parents who marry their young daughters before they reach puberty.

Imam (255) replied: "No. She should reach puberty and then can marry. She can be married but the husband and wife's relationship is only due when the girl reaches puberty. This is a must"

The focus group discussions provide insights into how religious and social practices of marriage and marriage rules are often blurred and/or contradicted. Bride price is acceptable according to Islamic rules in order to secure the future of woman. However according to many participants, bride price is for the benefit of the girls' parents. The issue of social practices of marriage is also brought up in an interview with one of the Human Rights' Transitional Justice Assistant, who was an Islamic cleric (253). She discussed about misconception around 'bride price',

"Mahr is the amount of money for the bride's future security. If she is divorced the husband has to pay it back to her. In Afghan society Mahr has become a business. Many families fight and do not continue the marriage ceremony. It is because they do not trust the groom and future life of their newly married daughter. Some argue that if they ask for a lot of money it would be difficult for the groom to pay it back and therefore divorce the woman in the future. However, parents take the advantages of their daughters' marriages and ask for 'bride price' (Toyana or Walwar or Gala). In Pashtons when the father receives Walwar that is calculated as 'Haq e Mahr' for the bride but her father takes it to his benefit. In Afghanistan, it is contrary that a father takes his daughters Mahr for himself. Another thing is the heritage that girls are not allowed to have a part of a shared property or inheritance."

“According to Islamic teaching, after couples vow ‘Haq e Mahr’ should be given to the bride. However they never give the money to the bride. They force a woman forgive the money to the husband. They see it as a treat for the man. Women are unaware of their human and Islamic rights and are kept in ignorance. Women usually follow what men tell them. In Afghan families sometimes a baby before birth is engaged to someone or after birth they give the name of a boy (specifically a cousin) to her.”

When I go to the provinces I talk to parents about many social issues, mainly related to women’s lives. I ask parents why you do not want your daughters to study. At least if they study they could become a teacher or doctor. They will know their individual rights. If they become educated mothers it would benefit their children too. However, people say that if our daughters go out of the house she will be called a bad girl or cheeky.”

Many participants discussed that another reason for marrying their daughters at a young age was insecurity. In other words, parents mentioned that they preferred marrying girls at a young age and thereby maintaining the family honour because in an insecure context like Afghanistan women and girls are more vulnerable to violence, including sexual assault.

Moreover, the social practices of marriage do not fully substantiate the concept of the father’s compassion the practices are driven by economic necessity and lead to demands for large amounts of money. This, practice also allows male members of the household to increase their honour and dignity among relatives and neighbourhood.

Whatever the true reason (s) for young age marriage involving the ‘bride price’, clearly the father receives financial benefits and the husband and in-laws are rewarded with an additional woman to service or assist in their home. According to 170 participants, husbands and in-laws do not properly honour and trust their brides, and the women do not have financial independence and the authority to express their opinions and make their own decisions in relation to their lives after marriage. A smaller number of women had more functional marital relationships and did not narrate stories of mistrust or dis-honour. These experiences, views and positive thinking offer hope for change.

The subsequent sub-section will discuss the impact of the absence of knowledge and communication around marriage and virginity, and demonstrate the magnitude of such issues in a newly married girl’s life.

7.2.3. Marriage night and virginity

The absence of communication and knowledge around marital life and sexuality can create a companionship-understanding gap that leads to numerous misunderstandings between husband and wife. In fact, the root of so many family issues, less supportive behaviour and various types of violence is miscommunication between husband and wife (AFGA 2012).

It emerged from research participants' interviews that the absence of harmonious communication between husband and wife around sexual and reproductive issues starts from the first marriage night. In the preceding section, it was noted that a large proportion of marriages are arranged. Girls and boys usually do not get a chance to speak in private and understand each other prior the marriage night. This creates numerous issues associated with sexual activities. Let's talk about Zarmina (32) who was engaged during her early childhood, and married after finishing her studies.

"I was married to my cousin and I never saw him before. I was afraid of my husband and I was not talking to him. I hated him because it was a forced marriage. I was crying during my wedding and all the way until we reached Pakistan. On my wedding night my husband entered the room and took my hand. He said, " I love a girl. She is my uncle's sister in-law (mothers brother). My mother liked you and chose you for me. Now you are my wife I respect you but I do not like you. My father is disabled, he cried and made me marry you."

"I just listened to him like a stupid woman and did not say anything. He did his job. I was shocked to see him touching me. He did everything forcefully and he hurt me a lot. I remained with this shock and whenever he wanted he was doing his job and was leaving me. I did not know how to respond. We did not talk to each other. He never cuddled me just take off my pyjama, and does that. (Intercourse). I was young only 17 years. I did not know about husband and wife relationships. I just knew that he is my husband and I should obey him. I thought this is life. How silly I was."

Although Zarmina was married off to her cousin she did not meet her fiancé until their marriage night. She talked about her broken conjugal relationship and sexual trauma. The quote demonstrated that Zarmina and her husband just lived together as husband and wife to fulfill the duty imposed by the decision of their parents.

Similarly to Zarmina, many participants shared their concerns over marital life and the state of shock from the first night of marriage. Some of them mentioned that they were so

concerned about the first night that they were praying that God should not make them ashamed. Asking the meaning of not being ashamed and being honoured in their in-laws' home, 211 participants voiced the importance of virginity and how it is associated with trust and honour.

According to the participants, in many Afghan families, when parents marry off a girl they usually advise her to be obedient, serve her in-laws, never complain and keep her husband and in-laws happy. However, there appears to be a wide spread taboo about discussing or providing information about sexual relations before marriage. Many HSPs and counselors spoke to me about the consequences of this. A female psychosocial counsellor during a focus group discussion (345) used one of her patients as an example. This data also indicates the importance of proving virginity at the commencement of the marriage.

“A lady on her wedding night went into shock while she saw her husband naked for the first time. She did not want her husband to touch her for four hours. Finally her husband told her that she would be liable to answer elderly women’s questions tomorrow and give them handkerchiefs with bloodstains to prove her virginity. The groom talked to his mother and then his mother called the bride’s mother at 4 a.m. in the morning. It was only when a group of women entered the bride’s bedroom to talk to her that her husband was allowed to touch her. It was quite sad that the bride told them that her husband tried to rape her. At 6:30 a.m., she was finally convinced that this was normal for a husband and wife. However, it was too late for her husband. After this incident, her husband did not touch her for 4 months. She came for counselling. She was telling to me that I was very stupid and I wish I knew all these things before my marriage. She is thankful for the counselling because I saved her marital life.”

Although, there is a large body of literature from many countries that virginity is not important anymore (Mebane 2006, Castañeda 2015, McHugh 2013, Christianson & Eriksson 2015, Schlegel 1991), virginity is much valued by families in Mediterranean and Asian societies (Wild 2015, Welchmann & Hossain 2005, O'Connor 2008, Wogan-Brown 2003, Kandela 1996, Gürsoy & Vural 2003) including Afghanistan (WCLRF and OSA 2015, AIHRC 2015b).

Since virginity is equated with honour and pride, which are vital in the lives of girls in Afghan society, evidence of virginity can secure a girl's future dignity in her husband's house (WCLRF and OSA 2015, AIHRC 2015b). Conversely failure to prove her virginity

may lead to her being sent back to her parents' house or being abused by her husband and in-laws. Sometimes due to lack of knowledge around virginity and sexual contacts, boys tend to seek their mothers' help if the brides fail to provide evidence (blood) of her virginity (Ibid).

Let's continue to find out more about Donya's (4) marital life status from her first day of marriage.

"While we were immigrants, I finished my school in Pakistan. After we came back to Afghanistan I studied economics. After my graduation from the university I got a job as a rate cashier. I was working in a female section but after marriage I had to leave my job. The guy who is my husband now saw me in the Bank's bus and liked me. He gathered much information about my personality and my family. Everyone has told him that this girl is very nice. He said that if ground touches the sky (by any means) he would marry her. When I heard this I just rejected this proposal and said that if the ground touches the sky I will not marry him. I said, "I am from Kabul and I will not marry a Pashto speaker." I said I do not know the Pashto language and my family are broad-minded. I knew he belonged to a very narrow mind family.

Then he said he would compromise. Then his family proposed to me for three years. My family said the same thing to his family. Eventually, I was married to him huhhh (sigh) it was my destiny. My mother told me get married to someone who loves you. You will have a decent married life." I was feeling very blissful. How did I know what problems I will face after marriage?"

Hay sister! I have seen many dreadful days. I can say that no one should get married. Throughout two years of my engagement, I did not know his character. I was sitting with my cousins and visiting my aunts and her husband. My husband never told me to avoid talking to them, especially male relatives. I accepted and I faced the curse of marriage from the first night of my wedding. When I was brought to my in-laws home, I saw they have everything but my room was very boring and untidy. I was shocked. He said that I did this deliberately because of your arrogance. You gave me hard time for three years and rejected me. Now I will break this selfish manner. My husband behaves like an animal from the first night of my wedding.

"First night of the wedding my husband started his violence to check if I am virgin or not. He was sleeping with me (having sex) and doing that from both sides (having anal and

vaginal sex). I cried and begged him not to do this. I told him for God sake, stop it, it really hurts. He continued doing the same thing every night. I was crying that it was very painful, but he was telling me “do not complain, let me make the shape of it (shape of the vagina). I could not tell him how much his forceful action hurt me.

“I was thinking all girls might pass although this phase of life. My mother-in-law told me that I should not do it (intercourse) less than six times. She told me: “If he falls asleep, you wake him up and tell him to do that for you. You should fulfil his passion.” She was listening from the backdoor. In my first days of wedding, if you would have seen my body, it was totally blue. He bit my entire body. I was feeling ashamed so no one could see my patches. If someone was looking at me I was thinking, she is looking on my patches and biting marks. The next morning my mother-in-law with some aging women came and told me what happened. I felt shy. One of the women started searching the handkerchief. She found and asked others to leave. I was dying from pain and very nervous because if my husband or elderly women would have said, that I am not clean (virgin), they would have killed me right there.”

“I never expect any romance or kind manner from my husband. He shouts at me and calls me to the room. He says come and sleep I need to do my work because I am tired so I want to sleep soon. In my in-laws home abusive words are common. They call me “hay” “hay khize” (Hay woman) they never call me by my name. I lost my identity. I feel very bad when they call me with some bad names ‘Fahisha’ (Prostitute).”

With a bitter smile she said, “I have many names but all are abusive. At the beginning, I was feeling shocked when hearing these abusive words. Now I am used to it. Sometimes I think. I should take a book and read it, but my eyes become blurred. In these six months, I became mad. I just lost my way and I feel like I am totally lost. I forgot myself.”

The story of Donya’s marital life shows that even she was educated she did not know anything about sexuality. Like many Afghan women she believes the conjugal relationship is something that the husband enjoys and the wife bears the pain. I learnt from many participants that issues around sexuality are not discussed at all. However in Donya’s case, her mother-in-law is involved in her sexuality and she observes their activities. According to Donya, she could not talk to her husband because the time and space for their proximity were limited. She only sees her husband for small periods of time, mainly when her husband wants to have sex with her. Opportunities to talk together are few.

The diminished status of women in the household frequently lessens as they age. When women reach a certain age they attain decision-making power especially around issues of marital sexuality of sons and daughter's-in-law. It is important to note that on the marriage night older women, mainly mother-in-law and some aging women (Groom's aunts, grandmother and sisters) tend to obtain information about the virginity of the bride (WCLRF and OSA 2015, Cook & Dickens 2009). Sometimes they enter the groom's bedroom early in the morning to observe the handkerchief with bloodstains. Sometimes they ask the groom about the bride's virginity status directly. After assuring themselves of the brides' virginity, the mother-in-law sends a message to the brides' mother that there is good news (Castleman 2011, AIHRC 2015a). This is the one time that sexuality is publically discussed within the female members of the family, and it is contradictory to everything that young people should be thought about sensitivity and sexual issues. Some human rights activists condemn this. One activist (253) said:

"On the one hand no one talks about sexuality to the newly married couple and on the other hand, the morning after the wedding ceremony, many elderly women wait outside the bedroom to hear the news that she was a virgin or not. I think that only the man and wife should know about virginity and these husbands and wives relationships are not to be shared. I think, it is a shame to discuss her virginity with other family members."

When a family is suspicious about the bride's virginity, they sometime take the woman to the health facility and seek confirmation of her virginity from HSPs. After examining the vagina HSPs will confirm whether or not the hymen membrane was already ruptured (Castleman 2011, Blakemore & Jennett 2001, Cook & Dickens 2009). According to the Afghanistan Independent Human Rights Commission report (2015) there is no scientific basis for establishing previous virginity. The Commission demanded that virginity testing should be banned by legislative decree because the honour, dignity and self-esteem of the girl comes under attack and frequently results in household or community elders punishing her. According to their survey virginity testing without the consent of the victim violates human rights and invades the right to privacy of the girl (AIHRC 2015b). I witnessed such a scenario in one of the health facilities. On a warm summer evening, in one of the maternity hospitals, a mother-in-law and newly wedded girl (414) entered the OPD section.

The mother-in-law asked for a senior doctor. It was almost 6 p.m. The night shift doctor laughed and said:

“What do you want from a senior doctor? I am responsible for this ward. Tell me your issue?”

The mother-in-law said: *“She is my daughter-in-law. Yesterday was her wedding. My son also accompanies me. Please check my daughter-in-law. My son says she is no longer girl (virgin).” My son said she ruined his life. He went to Iran and was working hard to earn some money for his marriage but she is just unfaithful woman. My son came to my room last night and he said, “ If you stab me with a knife 100 times you won’t see blood. She is not virgin!”*

It was a very emotional moment. The doctor asked the girl about it. She did not say anything. There was a handkerchief with bloodstains. Mother-in-law said, *“I saw the blood. It is not real blood. The colour is different. There should be more.”*

The doctor calmed them down and said, *“Let me speak to the girl.”* The girl only said: *“I do not know about it. It is my first time with him and I do not know what the blood colour should be.”*

The mother-in-law said: *“ She is my sister’s daughter. I know she is a good girl, but I do not trust her father. If her father has done something with this girl, what should I do then, my son’s life is finished.”*

The doctor said, *“It is a forensic case. Come tomorrow during official opening hours. The director of the hospital will write a letter and we will have 4-5 doctors as witness, then we will do the vaginal exam.”*

The girl was very pale and tired. Her in-laws and husband had beaten her up. The mother-in-law was begging the doctor to check her virginity and was looking with anger on the new bride. The mother-in-law spoke to the doctor:

“You are our last hope if you do not examine her, my son will not let her live.”

When she left with her daughter in law, her son was standing outside the health facility door. Looking at his mother he said, “I told you no need to come here. I am a man and I know it. My life is destroyed.”

As the doctor refused to examine her that evening, they had to leave the OPD section hopelessly. It is heartbreaking to wonder what may have happened to the new bride? I do not know whether they brought her to the hospital again or did something terrible to her?

In some Afghan families, in order to hide such issues and avoid facing up to blame by community member or relatives for lacking honour a decision is made to kill the woman. Such killings are called 'honour killing' (Chesler 2010, Shalhoub-Kevorkian 2005, Ayhan & Gökceciçek 2001, Solberg 2009, Welchmann & Hossain 2005).

A gynaecologist (304) during an interview talked about the lack of knowledge around sexuality and the importance of proving virginity.

"In our society no one discusses sexual issues. In our society it is either a shame or stigma. Our people are very modest. I worked in a private hospital and I came across many such incidents. Many women come for a check-up because they are worried about their virginity. Some girls told me that they fell down the stairs or some other reasons. They wanted me to check the hymen is intact because, if in the first night of a wedding the bride could not prove her virginity with blood, so she will not be accepted either in her in-laws or parents houses."

According to health professionals (301&237) and an AIHRC report (2015b) there are many types of hymen (a membrane that covers the outer layer of the vagina) and some might not bleed as a result of breakage after intercourse. If an unfortunate girl has an annular type hymen, she might not have bleeding and will suffer from stigma, hatred and torture of by her husband and in-laws. Furthermore, many men have inadequate and only anecdotal knowledge about virginity and sexuality (AIHRC 2015b, WCLRF & OSA 2015). Some men believe that the girl should have heavy bleeding. Others believe that after insertion (penis) along with bleeding a husband should hear sound of the hymen breaking. For instance, a female psychosocial counsellor (238) discussed a case of sexual assault by a husband as a result of this false belief.

"A man on his first night of marriage had sexual contact with his wife for the first time. He did not know if she was virgin because she did not have bleeding. Such kind of hymen is called among locals especially women 'Baadi' (windy). The man brought a tree branch and inserted to the girls' vagina to take revenge that she is not a virgin. She was brought to hospital with 4 degrees of laceration in an unconscious state."

Whilst some Afghan families seek HSPs advice, others do not. Instead they tend to assault the newly married woman for not being a virgin. One of the gynaecologists (304) during an interview shared similar issues.

“When I was in hospital, a lady came and said to me that her niece who is just 14 years old was married. She said, there is a big argument between our families and we do not know how to solve the issue. The man told his mother that he heard from his friends that there would be blood stream and all the bed sheets should become wet. I think that something is wrong.”

“I said, bring her husband here to the hospital that I can inform him about virginity. I think he heard from some vulgar friends that after insertion she might bleed like stream. I wanted to tell him that those women who have heavy bleeding it is because of laceration.”

The lady said, “The husband of my niece is not willing to go to the hospital. They put the poor bride under pressure and beat her. He recurrently asks her whom she slept with? The girl cannot eat anything and every moment faces torture by husband and in-laws. They do not allow us to intervene” Oh God! Someone should inform these people that there is no vein in hymen. There will be some drops of blood and some types of hymen do not bleed.”

Sometimes due to misunderstandings around virginity husband and wife are referred to the psychosocial counsellors. If the husband and wife are willing to participate in counselling sessions, psychosocial counsellors intend to get to the bottom of the problem: matrimonial relationships.

Lack of knowledge and inappropriate communication about the variations in female reproductive organs perpetuates ignorance, stigma and even violence towards many married women (AHRIC 2015a, Blakemore & Jennett 2001). Unlike all other sexual and reproductive topics, the matter is not kept private. Many family members become involved if the couple cannot or do not seek HSPs advice. Poor communication and knowledge about sexuality continues throughout women’s adulthood.

7.3. Adulthood

7.3.1. Marital Life

7.3.1.1. Women Perceptions Around Communicating Sexuality

Given the preceding sections, it is not surprising that research participants and some reports (WCLRF 2009, AFGA 2012) reveal that a large proportion of women do not communicate with their husbands about sexual issues. Such women tend to avoid talking about both emotional intimacy and sexual health issues. According to participants, when issues around sexuality are not discussed, husbands and wives often express their frustration through verbal and physical violence. Let's read part of the story of a Tajik ethnicity midwife Maryam* (1). Maryam came to the PNC room. It was the 20th day after the birth of her first child. With the excuse of going to her parents' home, she came to the district hospital to meet her colleagues and friends, and at the same time obtain painkillers and Iron tablets. Maryam told me that she has been employed in this hospital, but after she got engaged her in-laws did not allow her work. I asked Maryam about her life after marriage and she replied with a bitter smile:

“ I got married one and a half years ago. I just gave birth to my son. Well... Hummmm, bad things happened in my married life. You know one of his sisters was my class fellow. His sisters said, that they went to many places but my brother did not like any of the girls. When he saw me in my Institute he liked me and told his parents “I want to marry her. He got married with me. It was his choice. huhhhhhh (deep sigh). I think it was my destiny.”

I could see she copes with life issues by convincing herself her bad life circumstances are her destiny. I wanted to know why, if her husband liked her and married her, he is not supporting her. She started talking about the various types of violence she suffers from:

“First he hit me because he asked me to put on some make up. I hoped he would slap me (smiles) but he beats me with whatever comes to his hand. He has hit me with cable, water pipe, Sikh e Tandoor (metal skewer used in clay oven to bake bread), his fists and kicks. He broke my fingers. If I tell you my life story you will be amazed.

I was curious to know why putting some make up could end up in a physical violence. She explained:

* Participant name is pseudonymous

“When I finished my household chores I came to my room to rest. He made me put on make up. I told him that I am very tired. So then he started hitting me. After he hit me on my legs, back and face he started having... (Cannot say the word ‘sex’). When he finished, he just slept and left me in pain. Actually, he always does this. If he wants to sleep (having sex) with me, he never cares about my likes and dislikes. He does not talk much, he just does his job and sleeps. He never kissed me or hugged me. I feel shy to say that I also need some care and love. After he turns his face and sleeps, I feel very depressed and lonely.”

“I feel shy to say his (sexual) demand is high. One time, he beat me with ‘Sikh e Tandoor’ (metal skewer) because I went to my parents’ home and stayed for a night. Instead of telling me that he does not want me to go to my parents’ house because he wanted (sex), he got mad and spoke with his hands. He attacked me and started beating me. My in-laws were watching while he hit me and broke my hand and fingers. He did not bring me to a doctor and I put eggs with turmeric to feel relief from the pain and tied my hand with a piece of cloth. When my parents saw my hand they asked me, what happened? I told them that I fell down while cleaning the windows. They said why didn’t you go to the doctor? I said, it is not very serious and with this remedy I feel better.”

Maryam’s story is somewhat typical of many educated women. After marriage she lost her job and was not allowed to spend a night in her parents’ house. She was invited to her parents’ home this day as women usually spend the 20th day after their childbirth in their parents’ house. A substantial proportion of participants mentioned that verbal and physical violence is common in Afghan families. Simple issues between husband and wife that could be resolved through communication end up in verbal and physical violence.

Continuing with Donya’s life narrative (4) demonstrates the depth of miscommunication, lack of privacy and breakdown in trust and honour. She was an educated woman and lived with her mother and father in-law, six sisters in-law and 4 brothers in-law.

“My husband never sits with me. From morning, when I wake up I go to the kitchen to prepare breakfast. I brush his shoes and prepare his clothes. He leaves home for his office and comes back at 6 in the evening. I am busy cooking at that time. When he comes I bring tea and take out his shoes. Then he eats dinner with all family. I wash dishes and clean everything. He shouts at me to arrange the sleeping bed. He never has spare time to talk to me. He fulfills his need and sleeps (having sex). If his parents call him at

midnight and ask him not to sleep with me, he leaves the room and sleeps elsewhere for a week. I swear to God this happened to me several times.”

I asked: why did not she talk to him when they are in bed?

“One night I told him “ Look (his name), where is your friendship and love for me? You don’t even ask about me. You never say that what have you done all day? He said, I am busy at work and when I come home I feel tired. The next morning, after he left home, my mother-in-law told me “what did you say to your husband? Never ever talk to him about household chores or any women’s issues. If I hear it again, then you will see.” I know they hear through my door what do and say and if we have sex or not.”

When Donya tried to talk to her husband her mother-in-law threatened her for doing so. Due to the fear of being heard by her in-laws she lacks the courage to talk to her husband openly. In interviews several other women said that when they were trying to talk to their husbands they were restricted due to shame and fear of in-laws. Psychosocial counsellors during interviews and group discussions agreed that one of the reasons women avoid communicating issues related to sexuality or reproduction with their husbands is that they live in a joint family in houses where they be overheard.

According to the female research participants, living with in-laws has its advantages and disadvantages. Some women mentioned that they feel happy talking to their in-laws and when they are busy with housework their mothers-in-law or sisters in-law look after their children. Conversely others stated that they feel restricted living in an extended family especially when they want to eat something or go somewhere with their husbands. In addition, they mentioned that children’s fights usually generate great arguments among adult household members.

Basira* (38) a mother of three children discussed a similar issue. Her children were born in close succession. She came to the PNC section because it was the second week of her bleeding post childbirth. She had been bleeding since the 3rd day of her childbirth. I was amazed to see her visit report that her body weight was 43Kg. She was malnourished and anaemic, and she was breast-feeding.

* Participants’ names are pseudonyms

“I started doing my household chores from the 3rd day after childbirth. I live in a joint family. I cannot talk to him freely. When I was pregnant and I wanted to eat something I could not ask my husband because of the other family members. I am not permitted to eat anything without my mother-in-law’s permission. At night his mother listen through the back door. She wants to know if he gives me some pleasure. My mother-in-law says “ My son did not give me any so happiness how can I see you happy with him.” I feel ashamed of complaining about our broken communication (a lack of intimacy). Instead I sit and cry. My husband sleeps (having sex) during my periods and after childbirth. He never cares if I am in pain or I have bleeding. He slept with me after I delivered my baby. My mother-in-law and sisters in-law were laughing and making fun of me because I took a bath (bathing after intercourse is a requirement).”*

Since Basira was ashamed of complaining about her conjugal relationship to her mother-in-law. She could not voice her consensus about intercourse during her menstruation and post childbirth. The quote from Basira demonstrated that in some families, mothers-in-law control their daughters’ in-law even to the extent of controlling what they eat. When daughters-in-law feel so tightly controlled by their mothers-in-law they dare not to talk openly with their husband. If they do not communicate, it is hard to develop a mutual understanding.

Lack of hygiene and lack of communication about hygiene was a common complaint by many participants. I here continue sharing the life story of Zarmina (32) a nurse who was married to her cousin at a young age and became a mother of 3 children. Zarmina expressed her concerns about the husband’s sexual desires and her inability to speak about her likes and dislikes to her husband.

“When I go home from work, I do all the household chores and study with the children. He never cares about us. His sexual desire is very high. Most of the time because he wants more he gets mad at me. He says “ give me...(non verbal expression)” and never feels ashamed to do say so in front of the children. I tell him wait until children fall asleep, he lies on the bed and says hurry up hurry up and while asking for...asking loudly. If I do not give him at that moment, he wants (sex), he gets angry and sleeps in his room. If he is mad he does not sleep with me, but he takes a bath. I know he talks on the phone with other women and watches bad movies. I think he watches bad movies in his office on his colleagues’ computers. Then I prepare hot water for him and he takes a bath.

* The cycle of violence and women’s health consequences will be discussed in interpersonal violence section (7.3.4)

I have no idea what love and care is. Once he just asked me to have anal sex. I rejected his offer. He got angry and did not speak to me for a month. He also asked me to have oral. I told him that I say the name of God in my mouth how can I take your (non-verbal expression) in my mouth. That was the beginning of our fight. Most of the time we never kiss. I do not like to kiss him because he does not wash his mouth and smokes. He rarely bathes. That (penis) has a very bad smell. So if you feel the stale smell what ever you have (feelings) you just forget it. I just sleep with him for God's will. Hahaha"

"When he sleeps with me it is very painful. Once he is done then turns his side and sleeps. I even do not want to touch his... (penis). He says take it in your hand so I take his shirt and with that I take his manhood in my hand. I hate the sticky and smelly. Once he is done I just go and take a bath. I hate the smell. I think this is the reason that I am not getting pregnant again. Sometimes, he complains because I am a nurse, so I do something to stop pregnancy. Ohhh God I am blushing. I am sorry I share very bad things with you. I have never shared these personal problems with anyone. I feel I should tell you all the issues in my life. Once I was fasting. He said, I want it, I said, please wait until I offer my morning prayers then I call you. He got angry. After I offered my morning prayers I called him, he came to me and said who are you? I never count on you. He took his pillow and blankets and went to the other room." She cries... I just remained like this for years. He never says my wife needs something. She has some desire. I wonder how I became pregnant while I had no sexual interest with him."

I wanted to know why although she is a nurse and knows about SRH, she does not encourage her husband to be clean and hygienic?

"Isshhhh (sigh) I just spend day and night with him. Once during his intercourse I told him "Look, what did I do wrong that you got angry and did not speak to me. Please listen to me? You will not believe at the moment, which is hard for a man to leave, he just said, you are such a harsh woman and you do not have any value to me. He put is pyjama on and went to his room. He does not talk to me, how can I force him to wash his mouth or body before intercourse? I do not talk much with him because he never values what I say. I can say that in my whole married life my husband is financially dependent on me. He has never gifted me anything. He did not even give a hair clip to me. I was patient and never complained but I realized that he uses me like tissue paper and puts me in the garbage basket. I told him, I worked hard and bought a piece of land. I did another stupidity when I registered the property to my husband's name. Now when anything happens he says go

and leave me alone. However this home is the result of my hard work but he throws me out of the house. My husband has some sexual dysfunction. He suffers from premature ejaculation. I told him that it is a mental illness so let's go to a psychiatrist. I told him if your mind were relaxed you never would have this issue. He never listens to me but I encouraged him to go to the doctor. I hope he could go to the doctor because of his sexual issue and I could have a chance to introduce him to a mental health counsellor."

Even though, she is a nurse she could not articulate her feelings to her husband and encourage her husband to keep his intimate parts clean, which results in lack of mutual respect and increased distance between them. Although various Afghan and other NGOs stress that in a marital life both husband and wife complete each other and are responsible for nurturing each other's feelings and desires (WCLRF and OSA 2015, WCLRF 2009, AFGA 2012) this message has not permeated large sections of society. Thirty-five female participants mentioned that whenever their husbands talk to them about sexuality they feel shy and never want to show any reaction. A Pashton woman (100) said,

"When he wants (to have sex) he takes my pyjama off but leaves my dress on. I do not know anything about sleeping with him. I can never look at him. I do not know what he does. It is a shame if I touch his body. He says why you do not know anything. You should kiss me or show something (emotions). I feel shy. I do not know how to react."

It seems her husband wants her to have some response during sexual contacts but she cannot get past the shame instilled in her. She thinks having sex means pleasure for her husband. The majority of female participants who were interviewed, and took part in focus group discussions, also believed that as wives they are responsible for fulfilling their husband's sexual demands rather than each mutually finding pleasure. Halima was the first woman (33) who mentioned that she had expressed sexual desires to her husband but her husband did not value her feelings.

"Sometimes I fight with him and tell him that I work as a servant, I cook food, wash clothes, clean the house, prepare your clothes and look after your child. I am a human not an animal. I have desires. I also want you to care about me. He says, "If you are happy in this condition stay here. If not go to your parents' house." What can I do? If I complain to my brothers, they might tell me that it is Afghan honour and that you should compromise and be patient. How can I tell my brothers that he does not care about my needs and health? He come, does his job and leaves. I wait for 10 days or even a month. After he

finishes, I tell him what about me? I look at him and tell him that I waited for the entire month and you leave me like this. He smiles and says leave it for the next time.”

Despite the large number of women talking about unsatisfactory marital relationships, of 390 female participants, there were 30 women who did communicate with their husbands and showed mutual respect for each other's desires. They stated that a husband is someone close to them. If a husband does not articulate his feelings, woman should talk to him at an appropriate time. Regardless of what we have discussed, there were a few participants who communicated well about sexual issues with their husbands and enjoyed their sex lives. During a home visit a woman (189) was worried about not being pregnant again. She said:

“In the morning, my husband paid me some money and asked me to go to a clinic and check for pregnancy. I told him if I become pregnant again I do not let you touch me. He said, “fine. I sleep in other room but do not call up on me in the midnight.” Every time we sleep (having sex), I tell my husband use condom. Sometimes he doesn't want to use. Huhaah what should I say, it is my fault too because we enjoy without it (condom).”

This quote demonstrates that she had a good sexual life with her husband. When I asked how she could talk to her husband freely she said,

“We are more like friends than husband and wife. At the beginning I was very shy but my husband said, “the way I talk about my feeling and desire, you should also talk to me.” He said “if you do not tell me then, whom do you ask for your needs.”

This is a positive example, which is in theory should not be difficult for other men and women. Nevertheless, a large proportion of research participants did not feel comfortable about explicitly discussing their sexuality. Several women discussed their husband's sexual need but hardly talked about their own feelings and desires. As some participants, did not have the words to articulate issues around sexuality, they talked through non-verbal expressions.

The prevalence of women stories about poor sexual experience and communication raised questions about men's perceptions of sexuality and communication.

7.3.1.2. Men's Perception Around Communicating Sexuality:

It is challenging to obtain sexual health information from men in the Afghan context. Some of the following data have been compiled through secondary sources, primarily psychosocial counsellors, who raised the issue during a focus group discussion. Often data was obtained with the assistance of a male research assistant.

The counsellors stated that a large proportion of men do not talk to their wives about their sexual desire and intimacy, which leads to frustration. Counsellor (363) said:

"Some women do not respond to men's sexual desires and that causes depression, violence and hatred. For instance, when a man wants to have intercourse, the woman lies like a statue and waits for the man to do his task without reacting. In Afghan society there is a belief that men have sexual needs and women are married to respond to this need. In this case, women do not express their sexuality. As a result husband and wife remain unaware each others sexual needs and issues."

This perspective highlights how some men expect a response from their wives. However most women tend to avoid it. For instance a male participant (368) described his difficulties with his wife.

"She says "I go to the clinic" but she does not say why she goes there? She does not talk about husband and wife relationships openly. I am making love and ask her for ... (intercourse). She only likes the same position in a dark room. She even dislikes being naked. I cannot see her body due to the dark, but I fulfil my desire and I sleep. I think I will lose interest."

This quote shows that women's failure to talk about their sexual needs or health issues, may leave men ignorant and unaware of their thoughts, needs, lack of understanding and/or embarrassment. The psychosocial counsellors who work in one of the NGOs that provide health and household related counselling expressed their concern that even if some husbands desire emotional and physical intimacy, their wives deny and disregard this. A female psychosocial counsellor (238) shared a similar experience.

"I visited a friend. When we were chatting, I said, you are lucky that you are at home and you can look after your husband. I saw her husband had a bitter smile on his lips. Her husband said, " I always expect her to leave her household chores to come and sit with me

and talk for a few minutes so I feel relief.” He said “ when I come from work and put my hands on her shoulder and ask her how are you today? She says leave me alone I am tired. I washed dishes or cooked food.” He added ‘ my wife has the smell of fried onions or curries or if I talk she is irritated.”

The counsellor said:

“I can understand that men also have some sexual issues and their desire is overlooked. I told his wife in the kitchen that your husband is correct. She said, “ I feel shy,” I said, “why do you feel shy? He is your husband. Your husband has rights. If you do not share everything with him then who would you share with?” I said:

“You do not have much work at home. At least, if you wear clean clothes and talk with husband kindly it would be good. I also told her that when you sleep (intercourse) you should not feel shy about talking with your husband.”

I wondered how the psychosocial counsellors could talk so openly about conjugal relationships. One of them (364) said during a focus group discussion:

“We were also typical shy Afghan women. After working in this organisation and being trained by one international and many national senior trainers, we learnt about issues. It is a job requirement that we should just ignore all social stigma and clearly talk to our clients according to Islamic rules. If we cannot talk to our male and female clients, so how can we help them with their conjugal relationship? We also advise women on their SRH issues, but we draw on our life experience to do this because we did not have any official training. For instance we all know about pregnancy and post childbirth care from personal experience.”

Only a limited number of husbands and wives appear from the research data to have access to psychosocial counsellors and to share their sexual issues with the counsellor, which they have never discussed with their partner. There were many examples of families where husband and wife become upset over minor issues and many misunderstandings are out of a lack of communication and caring. The following quote captures the issues.

“She never cares about her hygiene. She cooks food and never changes her clothes. At least, if she properly washes her body and cleans her body (cleaning / shaving hairy parts of her body) she won’t smell bad. You know when I sleep with her, I feel her body’s bad odour and ‘eshthayam misoza’ (I lose my sexual desire). I do not tell her because she feels

ashamed. Once I was in the bathroom. I asked her to pour water on my head while I was shampooing my head. I could feel how stinky was that area (vagina) I said to her that she should consider hygiene. I said, from this distance I can feel her body odour. She got upset and did not let me touch her for a month.”

The conjugal relationship is important to these participants. This could seem counter intuitive in a society where many issues related to sexuality are hidden. Though perhaps it takes on this level of significance precisely because it is hidden, and because emotional intimacy also seems to be lacking in many Afghan family relationships.

From the 71 female participants perspective the conjugal relationship is often the only point of intimate connection that many women can hope to achieve, because the other routes of hope and affection are cut off from them. Results demonstrated that women tend to make conjugal relationships work for two reasons. One is to have one ally in the household who might stand up for her. The second is to have a sense of being loved by somebody. However they shy away from discussing about conjugal relationships and thereby strengthening mutual understandings and marital bonding.

7.3.2. Pregnancy and Childbirth

7.3.2.1. Communication Around Pregnancy and Childbirth

Based on my understanding of Afghan society, and evidence from participants, in Afghan families, pregnancy in the first year of marriage is highly prized, even if the newly wedded women are very young (less than 15 years). The major reason for young age pregnancy is proof of fertility, childbearing and providing services to in-laws and husbands (AMICS 2010-11, pg. 132).

The level of communication during pregnancy varies across different ethnic groups in Afghanistan. In Pashton communities, for example, newly wedded women tend to hide their health issues during pregnancy and childbirth from the husband and the in-laws. This is because Pashtons usually tend to marry a healthy girl who can both give birth to many children and also perform house chores for a large family. In addition, it is shameful for a woman to talk about her pregnancy or any health issues to household members, including female members and husbands (Lalзад 2008, Shahrani 2012).

Many interviews indicated that the majority of Pashton newly-weds women usually shy away from discussing health issues with husbands or mothers-in-law. These women have to neglect their health and wellbeing for the sake of keeping other members of the family happy. If a serious health issue affects her, the mother-in-law will be informed by her sister's-in-law instead. For instance, a Tajik woman (383) who was married to a Pashton man shared her experience of reproductive health during an interview.

"I had kidney pain and burning in urination and I was bleeding as well. In my all pregnancies, I suffered from 'Sozaak' (burning during urination). I felt too shy to discuss my health issues. People say bad things if you are ill and want to see the doctor. My mother-in-law did not want me to go to the clinic. She was telling me to give birth in front of her. She was telling me that when I can give birth at home and there was no need to go to the clinic."

I asked: 'Did you tell to your husband that you had some health issues during pregnancy?'

"No. Hahaheeh, how could I tell him? It is a shame. If I told my husband about my discharge and itching problems he would think that why he had married to an ill woman. I

was thinking leave it, I will never tell anyone. I even do not say anyone about my pregnancy. 'Shekam ma pot mikadom' (I was hiding my bulge of tummy) I got pregnant during the first 40 days after childbirth. I had delays in my periods and I thought it is because I was nursing."

I asked: "How was your husband and mother-in-law's behaviour during your pregnancy?"
She answered:

"If I die or live his mother never asks about my health. Once I was very ill during pregnancy. She got to know that I am pregnant. She did not want me to go to the doctor. She was telling me that all women have some health issues. All women get pregnant, but they never complain."

Another patient (99) said because of the social stigma and shame she did not ask for facility-based childbirth and even had to control her voice during childbirth pain so no one recognised that she is in labour.

"I was feeling shy so I did not tell anyone that I am ill (labour pain). My husband did not know that I was pregnant and about to give birth. After giving birth in my pajamas, I took my pajamas off and called my mother-in-law to cut the cord. My mother-in-law was telling me not to complain about pregnancy problems and pain during childbirth. It is a shame if every family member hears your voice. During my childbirth, I ate a headscarf. I put the headscarf in my mouth and when you saw it after childbirth, it is like a net. You would have thought that a baby cow had eaten it."

As women, especially Pashtons, who talk about pregnancy and acknowledge labour pain, are usually called cheeky or disrespectful they tend to tolerate the pain in isolation.

We return to the story of Donya (4) to learn more about her pregnancy. Donya was in hospital. She had an ANC visit and was referred to a gynecologist for further treatment. Multiple purple and green patches were visible on her face and hands. Her lips were cracked and she had a canola in her right hand and a bandage on her right hand. I discovered later that she attempted suicide but her parents saved her life. She was five months pregnant and wanted a health check-up in ANC room. I had a chance to speak with her in the hospital waiting room. She started speaking about her health condition.

"I am 5 months pregnant. The doctor checked me and saw my wounds. She asked me what had happened to me. I told her that my father-in-law beats me. Because I cannot speak Pashto language they do not talk to me in Dari. My husband said, " I thought you will learn Pashto. Now I can speak a little bit. So they beat me because they complain that why I am not learning Pashto properly. They beat me this much..."

She took my hand and it put on her head, and I felt the "goose eggs." She said, "They pulled my hair out, punched and kicked me and hit my head against the wall. My husband started beating me first and when he got tired handed over to my father-in-law. They first beat me on my head and then tied my feet with a rope and then beat me with a water pipe. My husband was telling my father-in-law that "Don't hit her stomach. No harm to the baby. Hit her head. It will be fine if she becomes crazy." I felt very disappointed that he was saying this. My husband loves me, but whatever his parents say he does it. I have no value to him. I was very ill and totally drowsy for four nights. My parents came to meet me the night before yesterday but my in-laws did not let them get in.

I asked if any of her in-laws interfered and stopped them from beating her? Was there anybody who supported her?

"No. I was alone and could not defend myself. All were standing and watching how I shouted and cried. When I said to my mother-in-law "please help me." She said "what could we do, our men are like this. Once they get angry they beat women and break their hands and legs."

After they beat me I had watery discharge. The water was oozing from my pajamas. I told my mother-in-law about my health condition. She told my husband "This is all drama. All women have some problems during pregnancy. Tell her to keep quiet. It is a shame to complain a lot." When I went to my parents home to visit them my mother brought me to a doctor. The doctor said "if you had not visited me you would have put your life in danger." The doctor prescribed me some medicine. The doctor asked for bed rest. I showed the prescription to my husband. He told his mother that my health is not good and I went to a doctor. His mother told him " never trust her. She is very smart. She might have known the doctor so the doctor said this to deceive us and rest all the day." My blood pressure is going high. When I told my husband that I was ill and the doctor prescribed bed rest, my husband said, " I do not believe you. You persuaded the doctors to say this."

When I came back to my in-laws house they took the medicine from me and left it in the storeroom. My mother-in-law said "No needs to eat unnecessary medicine." The other day when I was crossing the corridor, I saw that no one was there, so I went to the storeroom and opened the lid of the multivitamins bottle and drank it. I said, "If you do not let me take the medicine at least I drink this so it will give me a little bit of energy."

When I got pregnant, I was vomiting. My in-laws made me fast during the month of Ramadan. My mother and father in-law's room is in front of the kitchen if I wanted to go there they asked me the purpose of entering the kitchen during the day. My husband says "Women are nothing. They are made for men's entertainment. Women should bring kids into the world. I wish this baby in your stomach was a boy. I do not like girls."

"When they beat me a few nights back my mother saw me in her dream. I am very dear to them. My parents came to meet me that night but my in-laws did not let them get in. The next morning when my brother came to visit me, I heard, and although my health condition was very bad I went to meet him. When my brother saw me in that miserable condition, he started crying. I put my hands on his shoulder and cried. My brother calmed me down and said, "no worries your brother is alive." (She started crying...)

My brother said that he would bring me to my parents' home. My in-law's said if you wish to bring her to your home, then keep her there, we do not need her anymore. When my brother brought me to the hospital. I was forwarded from one hospital to the other. No one admitted me to hospital. They were telling my parents that it is a criminal case. My face was swollen and blue because they hit me in the face and I was bleeding all over due to broken teeth. Finally, I was admitted to a private hospital and they attached drips to me. I grew up in a family where I did not have a pinch. Now I can see my mother feels very sorry for my condition. My brothers tell me that if they do not kneel down and say sorry to you we will never let you return to that home. When I saw my parents' misery, I cut my wrist, but I failed to cut my vein properly. I felt so low when I saw my ailing father. He said, " I am sorry my dear. I am weak and cannot defend you." I do not know exactly what will happen? My brothers say that I should get divorce from him, but I am pregnant. I do not know what will happen to my baby?"

She left the ANC area with her mother and went to see a gynaecologist. She really needed to have some counselling, but she did not receive any advice and was not referred to a psychiatrist. She was only prescribed painkiller.

Donya's story is extreme, but elements of it match other women's life stories. Despite suffering from her first day of pregnancy on wards from morning sickness and high blood pressure, she was not allowed to go to the doctor. She did not have direct communication with her husband, because in a joint family, many other family members, especially her mother-in-law, take decisions about a woman's health. During interviews with one of the health promoters (299) more information about pregnant women's health issues and the behaviour of family members emerged.

"I saw many women who were ill in fact. The behaviour they face in their in-laws houses is appalling. Not only uneducated families, but also educated families never care about the health of a pregnant woman. A pregnant woman should be considered a patient. I even had the same experience in my own family, which is broad-minded. Nonetheless, they still follow the old ways of thinking. They need more awareness and information to change their mentality. For instance, elderly women say, "Any health issues we experienced and tolerated during pregnancy, she can also bear." Anything a pregnant woman hears from mother-in-law or elderly women she has to accept. She cannot reject or say anything because she respects them and because of her husband."

Many women said that their mothers-in-law and husbands usually do not take pregnancy complications seriously. To understand this better I explored 20 mothers-in-law's perceptions of pregnancy and childbirth. A majority of mothers-in-law commented,

"Today's women are made of plastic (artificial/ spoiled). When there is a minor health issue, they complain and want to visit a doctor. Pregnancy and childbirth are a natural process. All women become pregnant and give birth and do all the household chores without any complaints."

Such impossible standards are widespread. Pregnant women feel compelled to live up to them without complaining despite ill health. A Pashton woman (294), during a brief interview, mentioned that she never rests during pregnancy and post childbirth. She was depressed about her husband and in-laws behaviour towards her.

"I never rested. I had three days of childbirth pain and never rested. My in-laws did not permit me to go to the hospital and I had to give birth at home with the help of my mother-in-law. I could not tell my husband to take me to the hospital. During my pregnancies, I usually have discharges and itching, but I did not tell my husband or my mother-in-law. After my first childbirth, I could not urinate for two weeks. When I wanted to urinate, I was

crying from burning. I think something was wrong inside me, but my wounds healed without any medical help.”

Very few Afghan men become involved in women's reproductive health issues, pregnancy and childbirth. When a man wants to accompany his wife to a clinic or hospital visit, people tease him that he is wife's servant. Therefore men are socially restricted from walking side by side with women. In addition, men are not allowed to enter maternity health facilities. To avoid the stigma a female member of that family (mother-in-law or sister in-law) accompanies the pregnant woman to the health facilities.

It is not just social pressures and family restrictions that hinder women from accessing health care services. A number of women mentioned that because of poverty and the joblessness of their husbands they even did not ask to go to the health facility in order to avoid additional expenses. In fact, Afghan men of Tajik and Pashton ethnicities have a tendency to avoid being involved in women's health issues even if she needs his support at the household. Within my sample, over 130 women who had home-based childbirths have support from their mothers-in-law and sisters-in-law during their childbirth. Another 31 women mentioned that they had no one to support them during childbirth. And 13 women mentioned that they received support from neighbour or community birth attendants' during childbirth. A Pashton woman (384), shared her home-based childbirth experience.

“This was my 8th pregnancy. My mother-in-law supported me during my previous childbirth. However she is getting weak and encouraged me to go to hospital. I was very ill and had childbirth pain. I said to my husband that I have childbirth pain and I would deliver my baby. He said, “Do not lie. You look fine.” My mother-in-law was out at a funeral ceremony and when she arrived home it was 10 p.m. My husband asked me to provide food and tea for her. After I prepared food and tea for her, I went to ‘Paskhana’ (small toilet). My mother-in-law asked me what is wrong with you? You look pale. I said I have labour pain. She said “Why you didn't tell your husband so he could take you to the hospital?” I sat on my feet in the toilet and mother-in-law helped me in childbirth but I had a problem delivering the (placenta). She asked me to put my thumb in my throat and hair on my mouth until that was out.”

They believe that reproductive issues are the business of women. Men then refer their wives to elder women especially to their mothers and claim they know nothing about women health issues.

With my research assistant's help I sought to understand why some men from various ethnic groups deny their wives access to health care services at the health facility. A Pashton male participant (447) who was a governmental employee, said:

“Many Pashton men from provinces such as Kapisa, Logar, Maidan and Wardak are not very conservative. Men from these provinces allow their women to go to the health clinic, and a female member of the house accompanies her. In other words, she can have access to the health facility if accompanied by mother-in-law or sister in-law. The attitude of Pashton men varies according to their life style and education level. If a man's income level is lower than mine due to low literacy levels he might not be willing to allow his wife to go to the health facility. He might think of the financial side of going to hospital.”

Another Pashton male participant (449) explained:

“First due to poverty, men prefer not to allow women to go outside the house in order to save transportation and treatment expenses. If my mother or some other elderly women provides childbirth facilities, then there is no need for her to go to the health facility. Other experienced household women can help her. In case, her health condition is not improving, I will bring some medicine from the doctor or purchase from the pharmacy on her behalf. Secondly, the wider society is very harsh. Men look at women and abuse them verbally. If a woman goes out of the house alone, people, especially men believe that she has a date with someone. They will gossip that her husband is uncaring because he allows his wife to wander everywhere she wants.”

Another Pashton male participant (448) gave similar reasons for not helping his wife access to the health facility. He said:

“The security is not good so it is better for women to remain at home. If my relatives, cousins or some acquaintance see my wife going somewhere alone they might make negative judgment. They say “Cherta rawana da. Khawand worsara nesta. Wale nesta? Khamakha bil cha sara wada lari.” These sayings are common among people in order to verbally abuse women. These mean that if the woman goes out of the house alone people might ask “Where is this lonely woman going in this bad security situation? Her husband is not with her. Why he is not? Perhaps she has a date with someone.”

The above sayings are very typical among Pashton men. Tajik men hold similar views. An educated Tajik man (450) explained:

“I do not talk about women's health issues, if my wife asks me I refer her to my mother. It's a woman thing so why should I bother? My mother decides that a female member of the house should accompany her. The society is very dirty. If a young woman goes out, men on the roads stare at her and say many things. If she is pregnant or carries a baby people still talk. In this society, no one respects women. If a woman uses a public bus, people say, “Watch her tummy. There is no need for her to go somewhere. She should simply remain at home.” However, they do not know that she might need to use the transportation to reach home. If a woman takes a taxi then people say “Did you see that woman sat in the taxi alone? She might be a prostitute.” To avoid all these problems I tend not to allow my wife to go out of the house alone. Of course, these limitation cause many misunderstandings between husbands and wives.”

It seems the social stigma, poverty, insecurity and discrimination against women impact on the decisions of men from all ethnicities to prevent their wives from accessing health facilities alone. This does not explain why these men do not choose to protect their wives' reputation and safety by accompanying them themselves. However, there are some exceptions and some Pashton and Tajik husbands have changed their attitude and now support their wives by accompanying them to the health facility. A Pashton woman (70) during her ANC visit in a district hospital explained why her husband now accompanied her to the clinic.

“I am pregnant with my 7th child. I come to the clinic for my health check-ups without my mother-in-law's knowledge. My mother-in-law says “ we were delivering children in a tent or in a desert. Our husbands did not know that we were pregnant. No one knew that we were pregnant.” My husband respects his mother and whatever she says he has to do it. However, my husband listens to me too and whenever I am ill he brings me to the clinic without her knowledge. I never came for health check-ups with my previous children. Because I lost three babies, I asked my husband to take me to the clinic, and he accompanies me.”

Whilst this gives a positive message, she only gained her husband's support at the cost of three miscarriages. Some men have a different way of thinking. They understand that their involvement in women's reproductive health results from changes in lifestyle due to greater access to information. For instance, one Tajik husband (450) shared that

“Lifestyles have changed. Before our parents did not have much knowledge of health services, hospital based childbirth and family planning. There was only one official TV channel and they never had SRH related awareness programs.” Day to day, people become more knowledgeable. Men became aware even though their parents or elder members of the household did not like allowing women to go to the health facility. They changed their behaviour.” I think the media, access to different TV channels, the internet and health messages increase the level of awareness.”

“Life status is equally important. Previously, men could not pay the cost of treatment and childbirth. Instead they were relying on traditional treatment and home-based childbirth. However, many families are still under the influence of sociocultural beliefs. The young generation’s perception is changing. If a woman needs to go to the health facility for a visit during pregnancy her husband accompanies her and waits outside the health facility until she arrives back. I accompany my wife. I have my own car and she does not need to go in a taxi or public transport. I sometimes do not want to make my parents upset by telling them that I support my wife going to the health facility for obtaining contraceptives. I respect them a lot therefore, I make an excuse that I will drop her at her parents house. On way, I take her to the health facility. I know I am not permitted to go inside the female section. I support child spacing because I am aware that more children mean more responsibilities and more expenses. I also value the health of my wife.”

“I know that seeking the advice of elders is necessary in our social and family customs. Sometimes, if there are some inappropriate customs, and you know these customs will harm your life, then it is better to communicate and take a sensible action.”

Even though a few men at present only support their wives efforts to access health care services. These quotes indicate that social beliefs are changing. Behavioural changes face resistance during the initial stage but are adopted by men who are better off financially and become more accepted and widespread.

It is important to note that in Hazara communities, it is more common for Hazara men to be involved in women’s SRH issues, even though a large proportion of women have home-based childbirth. Hazara women can freely discuss SRH issues with their husbands and mothers-in-law. A Hazara woman (226) shared the experience of childbirth with the support of her husband. She said:

“When we give birth to a child, men try to support us in childbirth. The husband grabs the woman from the back and pushes her stomach so she delivers the baby. I gave birth to 10 children without any problems. In my childbirth, I just had my husband’s help. He was pushing my stomach and was lifting and shaking me in his bosom so I could deliver my baby easily and my mother-in-law was cutting the cord.”

A Hazara mother (201) also talked about men’s role in women’s reproductive health issues. While she took a picture with me, she was happy to share her childbirth experience.



Photo 17. Hazara mother was waiting for her daughter’s childbirth, outside maternity section of Dasht-e-Barchi DH

“We have a trend that with the help of men’s hands we give birth to children at home. When childbirth pain starts, they take a stick and walk until the ‘Nelgha’ (baby) is near to birth. Once we had a funeral ceremony and a guest came and slept at home. At midnight, I had pain and could not go to sleep. I went to ‘tawa khana’ (a place where they cook food and bread and use it as a store) and there was no light. I took a small fuel lamp and lit up the area. In order for my relative not to hear my voice, I was biting my fingers, and my fingers became black. My husband came and pushed my stomach and I gave birth.”

According to 9 Hazara participants, men of their ethnicity are more involved in SRH and even in childbirth, than other ethnic groups. A Hazara male participant (431) discussed the reasons why they allow women to go to the health facilities and why they get involved in childbirth.

“Hazaras have been through many adverse life circumstances. A substantial proportion of Hazara people (men and women) from childhood were serving wealthy families a few decades ago. For 10 years Hazaras have tried to obtain education and improve their life conditions in all fields of life. Our religious leaders permit all women to study and reach

high levels of education. Due to these factors Hazara men never mind allowing their wives and female family members attending health facilities to obtain health services. Hazara culture is not very restrictive of women in comparison to Pashtun and Tajik culture.”

In conclusion, from the data, it appears that there are two main gaps in reproductive health seeking behaviour. First, pregnancy and childbirth related health issues are not taken very seriously because in many households' mothers-in-law or sisters-in-law support daughters in law home-based childbirth and they do not feel the need to seek reproductive health services, relying instead on home remedies. These include the use of straw to ease childbirth, insertion of sheep dung to soften vagina, sitting pregnant women on warm bricks for pain relief, putting her hair in her mouth, to bite on and cause abdominal contractions though putting snuff on her nose or thumb in her throat to ease placenta discharge. In addition some religious beliefs make women obtain an amulet or obtain blessings from a religious person during pregnancy and childbirth in the expectation that this will save the mother and child from ill-health or death.

Secondly, a mixture of sociocultural beliefs, insecurity and poverty restrict women's movements outside the confines of the home and impact on SRH seeking behaviour. In many cases it seems pregnancy itself, or at least acknowledging pregnancy, is a stressful thing. Not talking around pregnancy, hiding a bulging tummy during pregnancy and hiding childbirth and breast-feeding are common practices.

7.3.2.2. High Fertility as Consequences of Son Preferences

Preferences for a son over a daughter are a long-standing cultural belief (Gayatri & Koolwal 2007, Sathar 1988, Bongaarts 2013, Pison 2004, Hank 2007) and contribute to higher fertility rate. Other reasons previously identified as contributing to a high fertility rate are: limited access to education and health services and women's insufficient control of their own health and bodies (Ahmed, Edward & Burnham 2004, Amowitz & Iacopino 2002, Mashal 2008). The preferences for son in South Asian countries keeps the high fertility rate despite the declined in global fertility rate (WCLRF & OSA 2015, WCLRF 2009, Amin & Chandra-Mouli 2014, Das & Monica 2003 & 2009, Guilmoto 2007, 2009, 2012a, Sen. 1990, Zeng 1993).

Several interviewees reported the honour given to a mother who has given birth to a baby son. However women who give birth to a baby girl are not honoured as much and to the same extent.

In most Afghan families, the preference for a big family is due to an eagerness for more sons. The research data from over 80 participants suggests that women, family members, especially husbands and elderly women prefer sons. A Pashton woman (385) in her 11th pregnancy wanted to have her ANC visit in the district clinic. She was pale and underweight according to the HSPs. In a response to a question about why she is getting pregnant one after another she replied to the HSP:

“My husband says “you should continue getting pregnant until you have 7 sons.” I have 7 children. Three of my children died. This is my 11th pregnancy.”

Similarly, a Pashton woman (88) who was in the district hospital to obtain contraceptives talked about the pressure she faced to have more sons. She was quite lively and smiling while talking to the midwife.

“I have 3 sons and 4 daughters. My husband likes sons and wants me get pregnant again. However, I clearly told him that in one-room rental house, how can we live and take care of children. What to do, he is a man! Hey, do you have any medicine so I could get pregnant with another son”?

The examples indicates that women have to respond to the demands of the husband and mother-in-law to have at least 4 sons, regardless of whether they suffers from anaemia, malnourishment or other pregnancy and childbirth related complications. Women's desire

for methods or medicine to conceive boys as a means of bringing a considerable level of honour and trust to the household are discussed below by one of the health promoters (309). She said:

“During pregnancy, no one considers women’s proper dietary and health needs. Many suffer from depression at having many daughters. Many women asked me, what they should do to conceive more sons. Is there any medicine or remedies for conceiving sons? They speak to me privately and say that no one values them in the household as their husband and in-laws want sons. I tell them that having a son or daughter is in God’s hand, we cannot do anything. Tell your husbands that they should accept God’s will.”

This research indicates that high fertility rates are particularly noticeable among those who prefer sons. The other reason for high fertility is men’s perception that the more children in the household, particularly sons, the more honour the family has. Over 72 interviews with women, men and family members indicated that husbands expect a big family and more children. In households where men have multiple wives, competition for sons is very high, which often leads to a large number of children in the households. Women agree to have more sons to boost the family heritage and honour.

My observational data includes over 30 instances of daughters-in-law and mothers-in-law being pregnant at the same period, with both wanting to have ANC visits. During an interview with a pregnant mother-in-law (186) and daughter-in-law (185), issues related to preferences for sons and competition among co-wives were discussed.

(185) “I have two sons and 4 daughters. This is my eighth pregnancy. We did an ultrasound test two times. The doctor said, “It is a girl but I think it is a boy.”

(186) “I have two sons. My first child was a boy. Then I got pregnant and in the hope of having more sons I gave birth to 9 girls, one after another. At least my daughter-in-law should have four sons. Her husband has a second wife. So there is a competition. She should bring more sons.”

The mother-in-law was motivating her daughters-in-law to have more sons by increasing competition among co-wives, but this hinders close relationships with co-wives, mothers-in-law and sisters-in-law, since they can often be jealous or very competitive. Some women desire more sons to claim greater attention from husbands and prevent him marrying another woman in order to have more sons.

Twenty two interviewees reported that after finding out that their baby is a girl, women sometimes make shocking decisions such as abortion, leave the hospital without taking their baby daughters with them or do not feed the daughter until she dies from hunger. Habiba* (17) a Tajik woman was brought to the maternity ward after her childbirth. She had post partum haemorrhage and back pain. Although she was moaning from pain she was interested in talking to me.

“It is my 3rd daughter. It is a girl again. I am not happy. I hope she dies. Since the day that I did an ultrasound test and the doctor told me it is a girl, I was very upset and wanted to kill her in my womb. I used some home remedies, but I became sick. That is the reason why I had my childbirth in hospital.”

She asked, “Do you have children?” I replied no. I have no children. She said:

“Take my baby with you. I really do not need her. Oh wait I will wash her face because she is dirty so you can take her to your home. I swear I do not need this girl.” I asked her why having sons is so important? She replied:

“Girls are not good because they born with bad luck and their destiny is always dark. From the day of birth they live with problems. Uffff! (Sigh) my heart is broken. My mother and mother-in-law are upset with me. They gave me some home remedies so I have sons but see God is not willing to give me a son.”



Photo 18. A sad mother with her girl-child

“I was 13 years old when I got married. My husband is 10 years older than me. Look at me I have suffered a lot. I have a stepmother. While I was a child I wanted to go to school, but there

* Participants' names are pseudonyms

were no schools for girls. Parents do not allow their daughters to study. My parents received a lot of money ('Walwar' bride price) and married me to this man. Girls are 'didanidar' (deprived). If it were a boy at least it would help his father. We are very poor because my husband works in a shop and we cannot afford a decent living."

I asked her how could she give her newly born baby to someone. Look on her face she is very cute. Suddenly the baby started crying. I asked her have you started breast-feeding? She replied:

"Oh leave it. I usually do not feed my children until I take a bath on my 3rd day. Actually, I do not want to feed her. She will die from hunger. iiiisssshhhh! (Exhaustion) I do not like my second daughter as well. She brought this girl after her. I am very sad because my children are all girls."

I tried to calm her down and stop her offering her baby to anyone else. It felt very sad to see a mother after 9 months of pregnancy and hardship trying to give her baby to someone else. Since the focus of my study was women's health, I obtained scarce information on the proportion of aborted baby girls during various stages of pregnancy and the destiny of those baby girls abandoned in hospital. I believe there is need to explore the extent to which new baby girls suffer. One midwife (301) commented:

"Son preferences make mothers frustrated and under pressure from in-laws and husband they do not dare to feed their baby girls."

Some reports (UNiTE 2009 and WCLRF 2009) have highlighted the pervasive issues of female infanticide and neglect of infant girls in South and East Asia, North Africa, and the Middle East.

I saw this pressure first hand one cold winter afternoon in ASB/DH, I observed a man (388) outside the male section waiting area. He seemed very tense and nervous. He was very mad. He was calling recurrently to his wife to ask whether the baby is a boy or girl? I met his wife just before getting out of IPD section. His wife had delivered her third daughter and her husband did not like daughters. He was expecting a son. He did not want to wait for his wife to be discharged 8 hours later. I saw him calling his wife and warning her not to come home. He asked his wife to go to her father's home.

"I do not need you 'Mada Posht' (means your eggs are all females)."

The term 'Mada Posht' is an offensive expression used by men and elderly women to those women who give birth to girls. Indeed, there is a misconception around girl childbirth. According to a WCLRF (2009) report and my research, mothers in the Afghan context are believed to be biologically responsible for the gender of the children. When a woman delivers more than two girls, she loses her value and honour and her husband tends to remarry in anticipation of having sons. In addition, a woman loses her identity and is labeled as "Mada Posht" (as above). Thus, as a consequence of giving birth to girls, women have to bear abusive verbal and physical violence of the husband and in-laws.

A midwife (267) shared her experience of dealing with a prolapsed uterus of a woman due to the decision-making delays for her hospital-based childbirth.

"A patient came with her prolapsed uterus. I saw and was thinking what is this. The other midwife said it is a baby. Pull it out. I said, no it is a uterus prolapse. I asked the patient's family that why she was in that condition. They said "We live in hillside and could not take her to the hospital. She delivered a girl and her placenta did not come out." Women told men that the placenta did not discharge and there is a need to take her to the hospital. Men were very angry on her because she gave birth to a girl. Her husband came and said, "How she cannot deliver her placenta and kicked her in stomach." After that incident this came out."

This quote illustrates the level of questionable knowledge among some HSPs. It is also a clear indication that how women are progressively dis-respected by being pregnant for a girl-child. Firstly, during pregnancy she loses the level of honour and dignity in the household and might not be fed properly. Second, I observed many women that after knowing the gender of their babies suffered from depression and anxiety. Many women expressed their concerns that their husbands warned them for not going back to her husbands' house if she delivers a baby girl. She is not taken to the health facilities because the birth of a girl does not bring happiness to parents and other household members. Thirdly, she often suffers violence after the birth of a girl child.

This research data shows, over 60 participants expressed preferences for sons over daughters. Various reasons were discussed including: fears of damaging honour and value in the household and being warned by husbands that he would remarry if they gave birth to daughters. Moreover they compared the Afghan social attitude anything a boy does, no one

blames him, but they always blame the girls. *“The girl gets pregnant but no one cares about the one who made her pregnant. They only say, “kill the girl” because she dishonoured us.”* These participants added that even if a family trusts their daughters and let them go out, people say awful things about their character and therefore they argued that raising a girl with honour and taking care of her is a challenge. Male participants mentioned that sons will carry on their family name and heritage and are financial resources to parents, but girls could bring a dishonour to the family.

In a focus group discussion, I shared my participants’ views with religious clerics and sought their perceptions. One of the clerics (373) said:

“In Afghanistan people usually prefer sons because in villages and remote areas boys at least can study but girls are not allowed to. Fathers usually want their sons to become religious scholars but girls can’t be religious leaders. It is further thought that prophets were men and a man can be a leader, therefore male preferences are higher in our society. I believe that if a man desires a boy before childbirth, it will be fine but if he regrets not having a son after the birth of the baby that is not acceptable.”

The quote illustrates how some religious clerics combine religious and social beliefs. According to the Book ‘Islam and Family’ (AFGA 2012). Islam prescribes high respect and value to women and Prophet Mohammad (BPH) strictly prohibited people from dishonoring girls. He encouraged people to celebrate the birth of girls. My research findings demonstrate that nevertheless even HSPs prefer sons and they expressed similar views. I obtained the views of a gynaecologist (304) in one of the district hospitals that offered some solutions for son preferences,

“I think that in order to decrease the level of son preferences, men should be informed that a girl’s gender depends on her father’s chromosome. The mother is not liable for delivery of a girl. A woman has xx-chromosome and a man has xy-chromosome. Foetal gender will be specified as female if the fathers’ x-chromosome links up with the mother’s x-chromosome. A second marriage is not the solution for those men who have daughters from first wife.”

This knowledge should help reduce the blame lied on women who give birth to daughters but not reduce the preferences for women to have sons. The next sub-section will address the issues around the determination of baby gender and its impact on pregnant woman’s health and well-being.

7.3.2.3. Determination of the Baby's Gender

The intense pressure women feel to give birth to sons is seen in ANC clinics where pregnant women seek to confirm the gender of the baby, often accompanied by family members, who are also anxious to find out. I observed a Tajik woman (96) in one of the districts comprehensive health clinics. She was 7 months pregnant with her 6th child and wanted to confirm the gender of her baby.

"I am in pain with this pregnancy so I came here for a health check-up and to obtain some medicine. I have 3 daughters and 2 sons. I hope this is a baby boy because my in-laws and husband like sons. My husband said, " this baby should be a boy." " Please doctor, tell me if this baby is a boy. My mother-in-law said it is a boy from watching my tummy shape."

During participant observation in one of the district hospitals, a Pashton mother-in-law (148), who accompanied her daughter-in-law for the ANC visit, asked the midwife about baby's gender. The midwife asked the mother-in-law to leave the room and allow the health providers to do the health check-ups. She did not leave the room and stood there to see how the health providers examining the pregnant woman.

Mother-in-law: *"How is baby? I believe that it is a boy. It is a boy no?"*

The midwife answered while smiling.

"I do not know I just heard the sound of baby's heart. My hand is not like an ultrasound machine, which can diagnose whether it is boy or girl?"



Photo 19. A Mother-in-law Accompanied Her Pregnant Daughter-in-law in ANC Section

Some women try to presume the gender of the baby by describing the shape of a pregnant woman's tummy or her habits during the pregnancy. Those who can afford it take the pregnant woman to public or private diagnostic ultrasound clinics in order to determine the gender of the baby.

Since HSPs do not have USG machines to check gender of the baby, pregnant women usually go to private USG clinics and perform USG tests every month of their pregnancy. This behaviour shows a great level of mistrust between patients and HSPs. Many HSPs during a focus group discussion shared their concerns over the pressure to identify the gender of the baby. A midwife (278) said:

“Patients are interested in Ultrasonography in order to look the gender of a baby, but never care about mother’s health. Patients ask me. “Do I need to do more USG tests?” I say no, instead of spending money on Ultrasound tests, you should eat something healthy.”

My data earlier discussed how women do not often go to health facilities for routine health check-ups during their pregnancy. It is a common perception that all women get pregnant and health issues during pregnancy are not a serious matter. However, obtaining USG tests to identify the gender of the baby is routine. My data shows that, in many Afghan families regardless of educational background, USG exams are conducted regularly especially after 20 weeks of pregnancy in order to identify and confirm the baby gender. In fact, if an HSP identifies the gender of the baby as a girl, patients usually do not trust the report and in anticipation of having a baby son, conduct the USG test again and again.

Let’s continue learning more about Zarmina (32) the Tajik nurse who revealed that she suffered from depression and anxiety after it was confirmed by USG test that her second baby was a girl.

“After my daughter was born, I got pregnant again very quickly. I was under pressure from my in-laws because I had a daughter and they were taunting me. It is unfortunate that after just one child they were judging that I could only bring daughters into this world. I went to... USG clinic. He diagnosed the sex of the baby. After knowing the news, I cried a lot and told my mother that this is a girl again. I did the USG test again and the doctor said it is a girl. My economic condition was not good. I was living in a rented house and I was thinking how many daughters should I bring into the world with such a bad conditions. I said, to my mother that my mother-in-law knew that I conceive more girls. I cried throughout the 4 months of my pregnancy. It had a huge negative psychological impact on me. I couldn’t eat properly and I even did not buy clothes for the new baby. The security conditions were not good so I had to give birth at home. When my mother was telling me it is a boy, I was thinking that she was telling me that to make me happy. I did not look at my baby all night and did not feed. In the morning, when I wanted to clean the baby, I saw that it was a boy. My husband said if you had given birth in hospital I would never trust you that this is my son. This is good you gave birth at

home so I can believe this is my son. We all were very happy and celebrated the birth of my son. USG diagnoses are not always correct. If they cannot make the right diagnosis, they should not tell patients about the gender of the baby.”

This quote highlights the feelings of a mother who received a diagnostic report about a girl-child. Although she is a midwife, she still felt reluctant to trust the test. She also knew that improper eating and grief could have a negative impact on her health and the baby's growth but she could not cope with this situation. Such strong response to hearing the news about carrying a female child is common.

My data suggested that malnutrition, depression and anaemia are commonly observed among women, particularly those who have had USG test reports, which identified a baby girl in their womb. Zarmina's story illustrates USGs are not always reliable. A midwife (353) in the maternity section of a district hospital shared another example,

“After childbirth I showed her the baby. I asked, “Did you see what the gender of your baby is?” She said, “Yes, girl”. I put the wristband on the baby and asked her again. She said, “boy”. I told her “didn't you say, that it is a girl?” She said, “in my USG report it was a boy”. I asked, “what did you see in your eyes?” She said, “girl”. I said, “You give birth to girl and now claim for a boy?” If I did not show her it would have been a big issue for me. I think it is better to show the baby. If it makes health complications we can take care of it but if she claims it is a boy then it will be a big issue. “In the maternity hospital they were asking us not to show the baby to the mother. After you make sure that the mother has discharged her placenta and she is not bleeding, then show her.”

Incorrect USG test reports and a high level of son preferences make women reluctant to accept that they actually gave birth to a girl. Showing the baby to the mother is a issue for HSPs who have to deal with the new mothers emotional reactions. The following HSPs shared her experience of an unexpected girl-child birth.

(265) “Last night we helped a woman deliver twins. She had two daughters and one son. She gave birth to two daughters. I asked her, “Did you do USG test?” She said, “Yes. The doctor said, one is a boy and one is a girl”. I was nervous how telling her that she has given birth to two girls. She was asking, “What are baby's genders?” I finally told her both are girls. She said, “Oh thank God at least they are healthy”. I was happy that at least I saw a patient who did not complain about having more girls.”

Twenty interviewees feel happy at the birth of a girl and stated that girls and boys are both God given gifts and these women were grateful to God that they had delivered a normal child. It can be argued that incorrect USG tests have a significant impact on the level of trust among patients and HSPs. Confusion about USG reports and seeing gender of the baby after childbirth result in conflicts between family members of woman and HSPs. This can also lead to abusive behaviour by the patient and her family members towards HSPs. As a consequence HSPs expressed reluctance at declaring the gender of the baby to the mother. They mentioned that showing the gender of a baby to a mother, right after childbirth, has advantages and disadvantages. Taking a proper history of a patient could help HSPs in decision making about declaring the gender of a baby. Some HSPs avoid revealing the gender of a baby or showing the baby to the mother right after her childbirth. However when HSPs do not show the baby to patient immediately, then the patient might claim that she give birth to a baby boy instead of a girl.

7.3.3. Family Planning

It is mentioned in the marriage section that pregnancy in the first year of marriage is common. Many women after first childbirth do not practice child-spacing and they quickly get pregnant again and again. In previous section, it is argued that a fertility rate in Afghanistan is high among women (6.6 per woman) because only 21% of women obtain contraceptives (AMICS 2010-11 and CSO/ NRVA 2011-12). My data suggests that there are many reasons for the high fertility rate and poor level of contraceptive uptake. First, husbands and wives do not usually communicate and plan to have children. Secondly, there are pressures from in-laws to have more children. Third, societal expectations mean that many believe it will be a sin if a couple abstains from sex to avoid pregnancy. From these reasons, even women who know about family planning find it challenging to access and obtain contraception.

7.3.3.1. Communication for Contraceptive Uptake in The Household Milieu

The linking of spiritual beliefs with contraception means women who desire contraception are accused of committing a sin and killing a life. It emerged from the data that a significant number of families tend to have more children even though they cannot afford to care for the children. Part of the reason for this is that, regardless of ethnicities, child-spacing is a taboo. Many participants believe that a baby is a God-given gift and refusing a gift is going against God's will. This is seen in the following brief interview with a Tajik woman (354) who was admitted to the maternity ward after giving birth to her 9th baby.

"I have daughters in-law and sons in-law. I have many grandchildren. I got married at a very young age. I was only 13 years old. I still live with my in-laws. In total there are 30 members in our household. This is my 9th baby and I had 4 miscarriages.

My husband does not permit me to use contraceptives. He says it will be a sin if you stop having kids. I told my husband "Please let me obtain some contraceptives. It is a shame that my daughter-in-law is pregnant and I am getting pregnant too". He said, "They have babies for themselves why should we stop having kids because of them. As many children as God bless us with, we will have. You should never stop having kids". What to do? He does not want to discuss child-spacing. I am getting weaker day-by-day."

A large number of participants and their family members strongly believed in God's will determined how many children people had. Going against God's will was perceived to be a sin.

During an interview with Lailoma*, a mother of 16 children and her husband (2,3) in one of the district hospitals, I tried to obtain their views around contraception. Lailoma was pregnant with her 20th baby. She has 8 sons and 8 daughters and 3 stillbirths. While she was moaning from pain and itchy rashes all over her body she said:

“In all pregnancies, I suffer from rashes and pain. My husband likes children and never wants me to avoid pregnancy. He says God blesses us with children and we should never avoid having children. In the 2nd or 3rd month, after childbirth I get pregnant. At the moment, I am nursing two of my babies and this new baby will be the third one. It is very difficult to look after three babies during the chilly winter.”

Observing the miserable health condition of pregnant Lailoma, it was important to obtain the views of husband about contraception. Her husband was waiting outside the hospital door. In reply to a question: “Are you happy having more children?” He answered very seriously.

“If God gives me 40 children, I would be very thankful to God. God gives life and provides food so why should I go against it.”

R: Your wife suffers from pain and itchy rashes, how can you help her?

“No problem. After delivery, she will feel better. I am happy that she gets pregnant and obeys what I want.”

This example is typical of many husbands attitudes towards contraception. More than 100 interviews with participants confirmed the refusal of husbands to discuss contraception, no matter the cost to the wife of more children. It may have been expected that mothers-in-law being women themselves, would see things differently but they also play a substantial role in their daughters-in-law’s multiple pregnancies. A mother of 7 children (69) talked about her mother-in-law’s involvement in her contraception decisions. She wanted to obtain contraceptives without informing or seeking agreement of the husband and in-laws.

“I came to the clinic to get an injection without my mother-in-law’s knowledge. Well, they are Pashton and like many children. I took pills for six months and then my mother-in-law found out that I am taking tablets. She took the medicine and asked me “what is this? If

* Participants’ names are pseudonyms

you take this medicine to stop pregnancy, it makes you infertile.” After she stopped me taking tablets, I got pregnant.”

It emerged from many interviews that misconceptions regarding the use of contraception leading to unwanted infertility, are most common in younger women. After having at least four children, women tend to obtain information about contraceptives from other women in the household or neighbourhood. When a woman is given the opportunity to go to the health facility, she might try to obtain contraceptives without discussing it with her husband or in-laws.

Over a quarter of interviews with women who wanted to obtain contraceptives show that women do not discuss this with their husbands or mothers-in-law for fear of losing the chance of going to the health facility and obtaining contraceptives (mainly injections). A 28 years old woman (30) wanted to obtain a contraceptive injection. She had 4 children and she came across oddly because a broken tooth affected her appearance. She sadly explained the reason for hiding her contraceptive usage from her husband.

“I do not want more children because if we do not have food for four children. There is no need to have more. My husband is addicted and he does not permit me obtain contraceptives. I ate tree gum but it did not work. I begged him let me go to the clinic. He started beating me and broke my tooth. My sister in-law told him that she wanted me to go to the clinic with her because she wanted to vaccinate her baby. Now I am at the clinic and do not want to lose this chance. Instead of being beaten up, it is better not to tell him that I take contraceptive.” She seemed exhausted and asked the health service provider.

“I heard that injection dries women (infertile). Please do me a favour and give an injection that dry out my roots so that I never become pregnant again.”

Many women are determined to obtain contraception. The following details illustrate their determination and what they will do to obtain it. A woman (157) without money for transportation was looking tired after two hours of walking to reach the health facility. After she entered the family planning room, she said:

“I wanted to have some protection for not being pregnant because for three consecutive years I had three pregnancies and doctors told me that I am very young (17 years old) and I do not have sufficient blood (low hemoglobin level).

I had a home childbirth. My mother-in-law helped me in childbirth. Although I had heavy bleeding, no one brought me to the doctor. In my previous childbirth, I was about to die so they had to take me to the doctor. The doctor said “You will kill yourself if you get pregnant again”. My mother-in-law told that I would not die from pregnancy. Because my husband and mother-in-law are against child-spacing, I made an excuse that I was going to meet my parents. Without my husband’s knowledge I want to have injection. Nobody will notice because I will not carry any medicine on me and I will feel safe for at least for three-months.”

She was confident that no one would know that she obtained contraception and that she would, remain tension free for the period of three-months. The HSP (86) asked her: *“If anyone sees your visiting card then?”* She replied, *“I will hide it under the carpet and because I am doing house-chores no one will want to check under the carpet.”*

This quote demonstrates the urge amongst women for contraception. The lack of trust and communication amongst her and family members are also clearly visible. Unfortunately, many such women do not always achieve their goal, as the lack of trust is also an issue in the clinics. From my data, women are refused contraceptives in the FP section on a daily basis. The main reason is a lack of evidence to prove that she is menstruating. A midwife (28) explained why mensuration is important in contraception decision-making process:

“If they have bleeding it means they are not pregnant and the cervix is open. We cannot trust the word of mouth. We need to see evidence.”

It must be very tough for a poor woman to reach the health facility without informing her family members and then leave the health facility empty handed because she could not provide evidence of not being pregnant. Indeed, it would be challenging for her to maintain her physical and mental health during pregnancy and childbirth.

7.3.3.2. Support for Contraception Uptake

Although the majority of my participants were not permitted to use contraceptives, my data does indicate that there are a few men who do support their wives’ use of contraception. A large proportion of men believe that child spacing is the business of women. Women should obtain contraceptives and should never ask for men’s involvement in their reproductive health issues, but some men are at least willing to using condoms. A Pashton woman (83) who wanted to obtain oral contraceptives said:

“Using pills made my tummy bulge and made me fat. I have to use it because my husband stopped using condoms. He told me. “ What a bad thing you found. It makes me numb. I do not take this anymore.” I had to start taking tablets afterwards.”

It seems that although her husband supports contraception, he tends to avoid using condoms and encourages his wife to use another contraceptive method. This indicates that he is not against child-spacing. He may be genuinely telling the truth because condoms could be awkward to use and disruptive to pleasure. A gynaecologist (202) said:

“Due to the social stigma and male hegemony, husbands are not coming to the health facility. There is broken communication link between husband and wife. Wives usually lack the courage to discuss condom use with their husbands. I prescribe condoms to patients who suffer from high blood pressure, vaginitis, cervicitis or pelvic inflammatory diseases (PID), I tell women “Ask your husband to use condoms”. They say, “How can I ask him to use condoms. If I prescribe medicine for her husband, they say, “I do not know if he will take these medicines. He might say that you want to kill me with these medicines.”

Wrong information and misunderstanding about condom use seems common amongst men, including medical professionals. Similar examples from other female participants confirm that several men did not want to support their wives' contraceptive use or drug treatment, particularly for the treatment of STIs. Several interviews indicated that those men who were willing to use condoms were not happy about the wives' contribution during the application of a condom. Out of 50 female participants who were obtaining condoms for their husbands, fewer than 5 women were involved in applying the condom. In a reply to the question asking that whether women check if their husbands used condoms properly or if they ruptured, a large number of women felt too shy to reply and few women did not know.

Conversely, some women told stories about the positive support and encouragement they receive from their husbands. A woman (180) who obtained condoms from the family planning section of a district hospital expressed her happiness about her husband's support.

“My husband has a taxi. Whenever I go to the health facility, he drops me in. I used tablets before. Because I am dear to my husband, he uses condoms and does ‘Ehtiat’ (abstinence). He takes care that I do not get pregnant.”

She was smiling while telling me that her husband is very well informed.

“My husband says, “We should have space and we should not have more than four children because I am very young.”

An older woman (95) reported that her husband began to support contraception later their marriage.

“At the beginning my husband was listening to his mother and never permitted child spacing. My mother-in-law is against contraception. My in-laws prefer boys therefore I have 9 children. Five of them are boys. My husband does not speak in front of his mother, but later he said, “Enough is enough. You should not be pregnant anymore”. If my husband did not understand my problems and did not support me, I would be unable to avoid more pregnancies.”

Formal education levels can also be a factor in husbands and wives making decision for the best health and well-being of woman. A young participant (31) describe this as follows,

“I was 15 years old when I got married. Now I am 17 years old. I have a baby. I just studied until class 4 then my parents married me. My husband and his family members are educated and my husband wants me to study and finish my school. I want to use some family planning methods. My husband and in-laws support child spacing. I do not know if it harms me to use contraceptives at such a young age. If I do not get pregnant again, I can get back to school. My mother-in-law will look after my baby.”

Research data from participants demonstrate that there are many participants regardless of ethnicity or education, who wish to practice child spacing. Some people link education with knowledge about SRH and uptake of contraception. Whilst, there is some evidence in my data to support this argument, the experience of my research participants suggest familial values have a greater influence on attitudes and behaviour.

7.3.4. Interpersonal violence

Interpersonal violence encompasses all forms of violence: behavioural, verbal, physical, sexual and economic. The multi-dimensional aspects of interpersonal violence can be seen through out women's life cycle (WHO 2010b). Earlier sections in this chapter show that violence is an integral aspect of many Afghan women lives and impacts on women's health and well-being throughout the life course. This section focuses explicitly on interpersonal violence.

It was discussed in the childhood section (7.1.1.) that daughters were seen as a burden and liability and hence poorly treated in the household. The data often shows that this occurs regardless of people's educational background and ethnicity. The data also shows how a great number of participants, mainly from rural areas, share their experience of being prevented from going to school and how they were forced to marry instead because the honour of their family was more important than the bodily and psychological well-being of young girls.

A study by Dupree (2011) noted that common causes of mental illnesses were commonly observed among those girls who were forced to marry at a young age. The research findings also showed that associated domestic, verbal, behavioural and sexual violence was the main source of their depression and other mental illnesses. According to my research participants, many adolescent girls were already familiar with verbal, behavioural and physical violence, and therefore accepted verbal and behavioural violence in marriage as a norm. Out of shame, fear, powerlessness and acceptance women do not complain or act to stop the violence, which worsens their mental health leading to a vicious cycle of ignorance, violence and mental illnesses.

As was mentioned in chapter 4 the cycle of violence also continues because of protracted war, economic constraints and deeply rooted social beliefs (Panter-Brick 2009 & 2011, WCLRF 2009, Eggerman & Panter-Brick 2010, WUNRN 2015).

However, my compiled research data from diverse ethnic groups in Kabul districts of Afghanistan demonstrated that interpersonal violence is tangible in women's lives in urban areas, where people live in relatively secure areas, are often well educated and have access to the social facilities and assets that comprised their social determinants of health.

I here would like to share a new section of Maryam's (1) life narrative. she is a middle class midwife who lives in Kabul city. In previous excerpts from her life story she talked about the lack of communication with her husband. In the following she relates how her husband beats her about small issues.

“He did not allow me to work in a hospital. Uff, you know during my pregnancy I was hit by him and my mother-in-law numerous times. Once there was a family wedding so my sisters-in-law asked if I could go to a shop and rent some traditional dresses for the wedding ceremony. Because I live in Kabul city and I have good taste they forced me to rent some lovely dresses. The next morning of the marriage party, they brought the dresses back to the shop. My sisters-in-law tore some parts of the dress and without repairing the damage just sent the dresses back to the shop. So my husband had a spat with the shopkeeper, and after he got home, he grabbed me by my long hair and locked me in my room. I was pregnant at that time. I had been washing clothes and I was feeling pain in my hands because of the cold. He started beating me with a stick and wire. I shouted, “Please for God sake let me know what is my mistake? Please help me. My baby will die in my stomach.” No one came to stop him from hitting me. He brought scissors and said, “I will cut your hair and nose so you can never go out of the house.” “He took my hair and cut it. Then started cutting my nose. At that point I crawled and escaped through the window. Since then I cover everywhere. One part of my head was almost without hair and one part very short like two inches. When I went to my parents’ house. My mother asked me to remove my headscarf. I told her it is good to have a cover I feel more comfortable with Hijab. I could not reveal that my long hair had gone. My mother was amazed and she said, “ You were very trendy before. What is wrong with you?” Huhhhhhh I do not mean to make my parents sad. I do not want to complain about anything to them.”

The PNC midwife who came to see Maryam was leaving or staying in the hospital overheard this and said:

“Oh that is why while I was asking her to remove her headscarf during childbirth she refused.” Maryam replied:

“How could I say that I have no hair? If I removed my headscarf, you all would laugh at my ugly short hair.”

She removed her scarf and I saw her hair was totally short and untidy. While showing her hair to me she smiled and said:

“My son is very brave. He is the only happiness of my life. From the day of birth till now he never cries. He fears from everyone from the days he was in my tummy. He knows if he cries then they will beat him too.” She had to leave because she was scared of her in-laws. She said, *“ There are many things I wish to share with you but I have to go. If I am late and they call to my parents home, then they will know that I spend my time somewhere else.”*

As she left, I could see fear and hopelessness in her eyes but also that she was hugging her son and smiling. Maryam’s life story depicted that not only a husband, but also other in-laws take part in perpetrating violence. She told me that her sisters-in-law instigated fights with her mother-in-law or complained to her husband so he assaults her.

Although, the law for the elimination of violence against women (EVAW) was ratified in 2009 in accordance with the Afghan constitution, the National Islamic Ulema Council of Afghanistan (NUC 2012) declared that any act of violence against women was considered justifiable under sharia law. Since, Islamic law and the Ulema’s statements exert a huge influence over human rights, family law and criminal law enforcement in Afghanistan (Rosen, L. 2000 Pp. 80–82, 168–69). According to Human Rights Watch world reports “We Have the Promises of the World” (2009 p.50) and “Women’s Rights” (2015) initiatives to eliminate violence against Afghan women and girls remain sparse (AIHRC 2015a and WCLRF 2013). Since the AIHRC report (2015) therefore concludes that enacting the Convention on the Elimination of All Forms of discrimination against women (CEDAW) in 2003 was purely symbolic act, the Afghan government has come under political pressure to do more, by international funders.

My research data demonstrates that, regardless of educational and economic background, 131 female participants mentioned suffering from at least two types of interpersonal violence (physical, verbal, behavioural, sexual, economic). These women often highlighted that they had hoped to be treated with honour and respect in their husbands’ houses after failing to obtain proper care and honour in their parents’ houses. Other participants of my study referred to individual acts of violence. The true extent of such violence in Afghanistan is unknown.

A report by WHO (2013) stated the highest rates of violence towards woman in South Asian countries such as India, Bangladesh, Bhutan, Nepal, Pakistan and Sri Lanka, where on in three women suffer from the burden of Intimate Partner Violence (IPV).

This violence was mainly sexual and physical associated with an absence of sexual autonomy, unintended pregnancy and poor levels of contraceptive use. Statistics related to violence in Afghanistan were not incorporated into this report but it does show that violence against women in South Asian countries is greater than in other parts of the world. In addition, as around half of female participants in my research reported violence, it may be that the rates of violence experienced by Afghan women throughout their life cycle are some of the highest in the world.

Paralleling Afghanistan, other South Asian countries (WHO 2013a & b, Sariola & Simpson 2011, Raja & McDougal 2015, Hampshire 2012) a large proportion of female research participants reported that they did not have control over sexual and reproductive decision-making through their life-course. According to my other research participants' perception, and my knowledge of the context, violence is associated with men's power of decision-making over women from birth to death. For instance, if a girl is young, her father or brother decide whether she can go to school or if she is allowed to leave the house. After reaching puberty and getting married, husbands, fathers-in-law, brothers-in-law and mother-in-law are the lead members of the household, and young women are not allowed to leave the house or seek health services without their consent. Table 12 summarises participants' information in terms of power of decision-making in their household.

Table 12. Power of Decision Making by Decreasing Order of Power (On Average)

Decision Making Power	Participants NO.
Husband	154
Mother-in-law	50
Other male member of the household (father, father in-law, sons, brother, brother in-law)	42
First wife/ husband & wife	8

According to Table 12, the findings from both men and women participants' interviews indicated that 154 husbands and 42 other male members of the household had the power of decision-making. One fifth of my participants indicated their mothers in-law were the decision-makers. Only 8 female participants revealed that they were the decision makers (two were first wives and 4 had mutual decision-making power in the household). The rest of participants did not discuss the topic.

Despite repeated statements of participants that women especially girls are kept at home for their safety most Interpersonal violence originates from social relationships within the household and women are usually abused verbally and physically in the family sphere (WCLRF 2009, AIHRC 2015a). The published literature emphasizes that most of the violence cases against women were practiced by men (AIHRC 2015a, WCLRF & OSA 2015, WCLRF & OSI 2006) however the collected data from my participants revealed that women also conduct violence against women and/ or force a male member of the family to torture or harass another female member of the household.

The annual report of the Afghanistan Independent Human Rights Commission (2015) identified multifaceted factors that exacerbate interpersonal violence within Afghan families. These include poverty and unemployment, insecurity, drug addiction, Illiteracy, low levels of public awareness, social practices of marriage, sexually prevailing and aggressive attitude towards women and social norms that consider violence against women as 'normal'.

In the family sphere women are usually abused economically because her in-laws pay for her marriage expenses and she has to pay the cost by serving the in-laws (WCLRF 2009, WCLRF & OSI 2010). There is also tendency to pass comments and abuse women outside the confines of the household. Additionally, women's hiding sexual violence and harassment due to fear and lack of trust in the government agencies and a lack of proper coordination between judicial and other relevant entities are also significant factors. Likewise, out of 390 female participants, 154 participants mentioned that they had confronted interpersonal violence particularly after marriage due to the husband's lack of life experience, addiction, lack of trust and honour, lack of proper communication, family members behaviour meddling by in-laws and poor level of sexual and reproductive knowledge. Some participants stated that they lost their identity, confidence and self-esteem after being married.

I would like to share the story of Shaima* (203) a Tajik woman from the Northern district of Kabul. Her story highlights various forms of violence through her life cycle. She was

* Participants' names are pseudonyms

admitted to the maternity section after her sixth childbirth. When asked about her health she said:

“Huh... I was about to die. I was in labour pain for 3 days. All the women who were there in the labour room gave birth, but not me. My husband had to bring me to the hospital because the state of my health was not good. My three daughters were born at home and the two sons were born in hospital.”

She continued talking about the reasons for not undergoing institutional childbirth.

“Ohhh! (Exhaustion). I have a cruel husband. He does not let me go anywhere. I knew how good it would be for me to have health checkups during pregnancy, but I was not allowed. My husband is very rude. I only go to my parents’ house, but cannot go to other relatives’ house. My mother lives in the northern area and my mother-in-law is old and she takes care of my other children but now she cannot help me with childbirth. My elder daughter is 12 years old and she is at home because my husband says there is no need for girls to study. Girls should do house chores but my son attends school. My husband is uneducated so he does not know the value of education. At every small mistake he starts beating me. He says, “This is my behaviour, you watch out!” I have been beaten many times. With fists, belt, wood and kicks. He even beats me during pregnancy. In month of Ramadan my father in-law’s brother come to our home and he was tired so he fell asleep. When my husband came and saw him he started beating me asking “why you walk in the room when he is asleep?” He never cares about pregnancy or my health. I lost my 7-month baby in my womb. It was my first pregnancy. I used to light the fire in order to boil water. (That time there was no gas or electric oven). He just came and kicked in my back and I fell into the fire ‘digdan’ and after three days I miscarried my 7 months’ old baby. I cannot complain. He is a man!

My mother-in-law does not say anything to her son. She helped me in childbirth and encouraged me to have a television exam (ultrasound). I did the exam three times because my husband and mother-in-law wanted to know if the baby was a boy or girl. When I gave birth at home, I used to sit “chondak” (on foot), in “paskhana” (a small dark and humid room that is usually used as storage adjacent to the main room) and my mother-in-law was messaging my back. She was pouring hot water on straw in a bowl and was taking in front of my ‘jan’ (Vagina) to moisten or soften the area for childbirth. After childbirth she was putting my hair into my mouth and pushing on my tummy until “jora” (placenta) was out.”

She was looking at the ceiling and trying to remember the time when she could not discharge her placenta and suffered very poor health.

“Huhhh (sigh), once I could not discharge my placenta so my mother-in-law tried many things. She even put snuff in my nose so that if I sniff it and sneezed so I would discharge it. Nothing worked. I had to suffer very bad bleeding for 4 hours. When she was pulling the cord that also broke. Finally after pushing my stomach and putting her hand inside me, God was kind that the placenta came out. I had bleeding afterwards, but I had to be patient. You may believe or not that my husband never even brought me a Paracetamol tablet. He never valued me. I was in pain and burning with fever 4 days ago. I asked him if he could bring me some painkillers. He said, “Oh forget it.”

I could see her eyes filling with tears. She was biting her lips in order to hide it and continued talking in a weak voice...

“I cry and do not say anything. I sometimes tell him “Do not bring medicine if I die then no problems”. I said to my husband “ you are healthy so you never feel my pain...”

She cried and cried and could not stop crying...I tried to calm her down, I asked her if she died what would happen to her children? She said:

“When I did television (Ultrasound) test my sister accompanied me. My husband said, “My baby son should be healthy I do not care for his mother”. My sister said, “If she dies then who will take care of children?” He just turned his face away. I told him to change this behaviour, but he said, “This is my behaviour and I cannot change it.” If he is in a good mood, I sit and cry. I tell him “I supported you during all the ups and down of life. You told me not to go out and have full cover dresses and I accepted. Why do you beat me and misbehave with me?” He says, “I am like this.” He dislikes, fashion, nail polishing, short or tight dress, makeup and plucked eyebrows. I follow what he wants. Whatever he wants I do it.”

“We sleep separately. He says, “You should come to my bed”. If I feel shy and could not go or fall asleep, then in the morning he is angry and does not talk to me. During my periods he wants it. I tell him I do not like it during my menstruation. I have been beaten many times because of this. If I deny (intercourse), then he gets angry, does not go to work for two or three days, damages everything and beats the children and me. Everyone knows

about this funny behaviour. It is so shameful but I am scared of him and too shy to tell other members of the family "What is he angry about?"

I felt that she trusted me and opened up. Conjugal relationships are a sensitive topic but she continued telling me about her husband's sexual behaviour.

"I told him a thousand times "Just go and have another wife. Let me live alone with my 5 children." Sometimes when I am exhausted I ask him to go and find someone else to relieve his need. He is a shoemaker and he cannot afford to marry another woman but he behaves very harshly. He says, "I have my rights and fulfil my sexual needs legally. I am not doing anything wrong." Sometimes his brothers say, "He is not a kid, he knows everything but he should change his attitude."

There has not been a day that I felt happy and had a smile on my lips. I never had any happiness. He never spent a day with me happily. A desire remained in my heart that one day my husband will ask me "How is your health or what do you need? " Let's go to the doctor" or at least talk to me kindly." Cries

"I just pray that God gives me death. What should I do if my existence is no longer important to anyone? I was under pressure and I took mouse-killing drug and wanted to eat and die. When I was looking at my children, I could not eat and could not stop myself from crying."

She said that she was born unlucky and on reaching puberty she was forced to marry a man whom she did not know. She mentioned that she was not allowed to go to school. Then continued,

"During the Taliban regime after one year of having my menstruation I got married. I told my parents that they had married me to someone who killed my feelings and dignity everyday. After getting married I fell pregnant again and again, but he did not allow me to go to a clinic and obtain something to stop pregnancies. I feel very sad when I see my brothers-in-law caring about their wives and bringing them to the doctor. When I get ill I just beg medicine from my sisters-in-law or mother-in-law. My sisters buy clothes for my children and me. They call me and ask about my health until my husband goes mad at their concerns and starts beating me. My mother and sister avoid coming to my home because they are scared of his unruly behaviour. My mother had an operation but he did not allow me to visit her.

Today during my childbirth, while I was dying from childbirth pain, he called me and asked me to leave the hospital. He said, "You have been like this for several days and you do not give birth. Just come out of the hospital." At that time, I could not move. After childbirth, I had to spend 6 hours here. Did you see? That lady guard went to find him in order to discharge me but he is not here. He might be annoyed because I did not leave the hospital right after his call. He switched off his mobile and I do not know my home address. How can I go home alone?"

She remained at the maternity ward for hours. While I was in the maternity ward, she was eagerly waiting for her husband. Her mobile did not have credit so she asked a midwife to call her husband but his mobile was still switched off. It was late evening and was getting dark. I had to leave the hospital and I do not know what happened to her.

Shaima's life narrative illustrates the extent of interpersonal violence in so many life stories. It clearly shows that some common aspects negatively influence interpersonal violence in the household and the Afghan society. In total data indicates that 53 women dealt with sexual violence by their husbands. In addition, the data reveals that more than 25 women, complained about coerced sex during their menstruation and post childbirth just like Shaima. In a similar way to research by Dupree (2011) and Panter-Brick (2011), my research mainly suggests that coerced and unsafe sex, especially during pubescence, periods or post childbirth, is fuelling violence against females and causing mental illness among women.

According to the research data, the consequences of interpersonal violence carry over from a girls' childhood to her married life. The Afghanistan Independent Human Rights Commission (AIHRC 2015a) report, registration of sexual violence (marital sexual assault and rape, sodomy and forced prostitution, forced watching of pornographic films, forced pregnancy, sexual torture, extramarital affair) is increasing. Although the number of cases alarming, many papers (WCLRF 2009, UNAMA 2014, UN Women 2014, WCLRF and OSA 2015) reported that the real numbers are higher. Afghan women, in fear of not bringing any shame to the family and not losing honour and trust tend not to complain about mainly sexualised violence.

7.3.4.1. Smart Phones and The Use of Sexually Explicit Content in Gadgets to Exacerbate Violence

Mass media is a powerful force for increasing people's awareness around SRH (Mmari 2014, Chandra & Martino 2008). However the mass media also can have a negative effect on SRH. Easy accessible sexual content is widely available in Afghanistan (pornographic images and videos, internet, smart phones, magazines, cards and other sexual material) (Malamuth 2011, Rosenberg & Kraus 2014, Cooper & Burg 2000, Wallace 2011, Coppersmith 2000 & 2006, Hald 2007, Wallmyr & Welin 2006). Some research papers argue that sexual content or use of pornography is healthy and might not result in aggressive behaviour in men (Hald & Malamuth, 2008, Paul & Shim, 2008, Weinberg & Williams 2010). Others refute the idea of healthy pornography usage and note many examples of sexual content impacting on men's attitudes to perpetrating violence against women, intimate partner violence (IPV), aggression and rape (Hald & Malamuth 2010, Wright & Malamuth 2011, Bridges 2010, Sun 2008, Hasrat & Pfefferle 2012 and IPPF 2010). The growing phenomenon of smart phones pornography has been noted in other countries (Malamuth 2011, Rosenberg and Kraus 2014, Cooper, Delmonico, & Burg, 2000, Wallace, 2011, Coppersmith 2000, 2006, 2008, Hald 2007 and Wallmyr & Welin 2006, Malamuth & Addison 2000) but this is a relatively new phenomenon and there has been no research on the phenomenon published in Afghanistan.

According to research participants, men who have smart phones would watch pornography, and ask women to perform the same things as they see on the screens. For instance, some women were asked to perform oral or anal sex but refused. Then they were sexually and/or physically abused and coerced into sex. Since women face various types of violence during their lives, a great proportion of them believe violence is inevitable (WCLRF and OSA 2015, WCLRF 2009).

However some women mentioned that their husbands also had an interest in taking arousal tablets. (I disregard this topic due to insufficient data. However, it would be interesting to research the perception of men around sexual arousal tablets and energy drinks). Data from interviews and focus group discussions highlighted that many participants were concerned about the levels of physical and sexual violence, particularly after their husbands' consumption of sexually explicit content via smart phones.

Though Afghanistan is very poor, and trying to recover from over 35 years of war, mobile phone ownership is very high among men. The social media and mobile industry started booming after the establishment of the new Afghan government in 2001. After the end of Taliban regime and years of political instabilities, over 5.8 million Afghan refugees started repatriating from neighboring countries (UNHCR 2015, MCIT 2015). It is estimated that migration has increased people's knowledge and demand for social media and mobile phone use. According to the Ministry of Communication and Information Technology, over 19 million of Afghans (80%) have access to mobile phones (MCIT 2015). One of the Afghan Human Rights Commission office (AHRIC) staff (253) during an interview mentioned that sex video clips are shared through smart phones. Despite the barring of sexual content on free to air TV channels. Men's access to pornography via social media is easy and pornography is also shared between men.

It is not just from the Internet that is shared. During my observation at the AHRIC, numerous participants reported being filmed by their husbands during sex in addition to sexual violence. Their refusal to use various types of sexual positions and their complaints about sexual violence led to more physical and mental violence. I heard many dreadful examples of sexual violence linked to mobile phones usage. One example comes from Justice assistants (342) and the legal advisors (341) in AHRIC office who shared the story of a woman who twice registered her complaints about her husband's sexual violence.

“When I have my period my husband asks me to sit and he makes a video of the blood drops. He forces me to have anal sex and beats me in front of the kids. He touches my body and uses very offensive words in front of the kids and spoils them. He makes video clips on his phone. My husband carries his smart phone and the memory chip with him everywhere he goes. When he sleeps he leaves them under his pillow and if he takes a bath he brings them with him in a fear that I steal or report them to anyone. He might sell those video clips and earn money from it.”

According to some participants, smart phone use has other negative influence on their marital lives. For the women above it normalizes sexual violence to her children. Around 20 women reported that their husbands had sexual affairs with other women via smart phones. This exposes women to humiliation and STIs. I met a Hazara woman in Pul-e-Khoshk CHC. She (395) was 20 years old. She married at the age of 17. In the three years since her marriage she has been very disappointed with her marital life:

“He makes video clips from our sex. If I reject anal sex, my husband beats me with a wire. My husband is fixing dates with other women by phone. However, he is a daily laborer and his income does not fulfill the daily needs of my child and I. If I take bath my husband suspects that I slept with someone else but I never have the right to ask him who else he is sleeping with?”

She had no rights to go out even to the health clinic. However, because she was suffering from pain in the lower abdomen and discharge, she eventually went to health clinic without informing her husband. This quote was similar to Shaima’s (203) story because her husband’s coerced sex during periods and post childbirth had adverse impacts on her bodily and mental health.

In a summer’s warm day, I met Halima* (33) in Bagrami CHC. She wanted to obtain some medicine for her pain and discharge. She was looking pale and skinny. Although the visiting room was very warm she had a burka on and did not want to uncover her face. The midwife asked her to show her face. She said:

“I am scared of my in-laws. If anyone sees me here then they will tell my husband and he would kill me. He never allows me to step out of the house. I have pains in my back and abdomen and I discharge.”

She had Pelvic Inflammatory Disease (PID) and secondary infertility.

“I have one son. I want to have more children but it has been many years that I suffer from pain and discharge. I swear to God! My husband never cares about my son and I. He is too busy with other women to remember us. He worked in an organization and had affairs with women. He lost his job. For 4 years he has been busy with other women and contacts them by mobile phone.”

I asked her how she was sure of this? Did she have any doubts?

“Doubts? I am telling you for sure. All day he is busy talking to women on his mobile phone. He talks dirty to them. If I complain, he beats me like a dog. During my periods, I cry and shout from pain. I have discharges and never can keep my pyjama clean. Some relatives gave me home remedies for the treatment of pain.”

* Participants’ names are pseudonyms

I did not take any medication. I tell him "Give me money for medical treatment or at least let me buy poison and die." He says "Go to hell." I feel very upset about why he has such a terrible behaviour with me. I am heart broken." She cries...

"He got married to me but never liked me. He says you are too skinny and you have nothing in your body. He never likes condoms. He does his job and leaves (having sex). How can I be fat if I do not eat properly and do not have peace of mind? How can I gain weight watching my husband talk dirty on the phone? He watches bad movies (porn movies) and asks me to do the same thing that women do in the movie. When I reject, he says "There are many women who can do this for me and give me more pleasure." He talks with women through his mobile in front of me. He fixes dates and meets them. I feel dishonour and cannot bear listening to all this nonsense. I provide warm water for him to take a bath every day (after his intercourse he takes a bath). I know that he gets more pleasure from other women than me."

A number of female participants indicated that they were confused about whether anal sex is acceptable in Islam or not. They noted that after rejecting such action the husband convinced them by saying that the Mullah allowed him to have anal sex with her. However, according to Islamic clerics (255-6-7-8) during a focus group discussion, anal sex and sex during menstruation and post childbirth are forbidden under Islamic Shariah law. Imam (256) said:

"That person becomes non-religious if he commits sodomy. If a husband demands anal sex, divorce can occur. Shariah says look after your wife's health issues. During menstruation, she can sleep with a husband if she does not bleed, but it is better to sleep after bathing."

Imam (258) said: "Those who claim that Imams allowed this act are totally wrong."

The above information indicates that much vital information related to SRH is misinterpreted or mis-represented. There is some debate in academic literature about the net affect of smart phones and availability of sexual information. But negative and positive consequences have been demonstrated. For example, positive use of social media and smart phones can be crucial for improving and understanding sexuality and sexual health issues (Hald & Malamuth, 2008, Paul & Shim, 2008, Weinberg & Irizarry, 2010). Social

media and smartphones can educate people about human rights and encourage men involvement in women's health issues. Keeping men well-aware of sexual issues and side effects of unsafe sexual activities would help them understand not only about women's health issues but also their own body and health (WHO/UNF 2015, MICT 2015, USAID 2015, Franz-Vasdeki. 2015).

This is important because as HSPs acknowledge, main reluctance to attend health facilities or accompany their wives needs the treatment of women with STIs and PID will be troublesome and lengthy. They will be susceptible to being infected again and again. Therefore, bringing a revolutionary change in people's knowledge, understanding and perception about SRH via smart phones would bring about a significant change in women's general health and well-being and reduces level of interpersonal violence. It should help turn a negative into a potential positive and start to break down some unhelpful taboos.

Still some men are ambivalent about this. A 41-year-old Tajik married man (448) talked about his sexual knowledge during an interview with a research assistant.

“Nowadays smart phones and the Internet have made it easier for us to explore and search for topics of interest. I have a smart phone and most of the time I browse the Internet on my mobile. While I was young we did not really know anything about sex. I remember I only saw nude pictures of women on playing cards and that aroused me. After I was married, I only knew one sexual position. However presently I know several things about sex. The only thing that I am unhappy about is my wife and young children's access to smart phones and the Internet. I doubt if they learn these things. It would not be good.”

7.4. Aging:

7.4.1. Aging women's Health status

In many contexts, aging women are tending to live longer (WHO 2013c, WB 2013b). However in Afghanistan, after suffering from the burden of SRH, violence and mental health issues, a vast number of women age quickly. Very old women are relatively few in Afghanistan {Currently, over 50% of the Afghan population is under age of 18 and a larger proportion of these are girls (WCLRF 2009)}. In Chapter 4, section 1), I addressed the dynamics of life expectancy among women, which was estimated at 49 years in the Afghan Mortality Survey (2010) and the World Bank (2013) reports. It was also discussed that such estimations are not reliable due to the absence of a proper civil registration system.

Photo 20: A mother-in-law in her home listens to an MSI marketing officer talking about contraceptive methods. However she did not allow her three daughters-in-law to meet these officers.



During my collection, a few women mentioned they were 'dried out' which means they experienced menopause. Since I collected most of my data at the health facilities, the vast majority of women who were grand mothers or in their 'late' adulthood were still fertile. In other words, since my primary concern was about women in their fertile years I did not obtain much information about menopause.

I noted in earlier chapter that there are no specific health services for aging women who have reached the menopause or suffer from some SRH issues. It could be argued that menopause is less of a concern because a large proportion of women die before reaching the age of menopause. Some aging women in interviews did say that they suffered from diabetes, high blood pressure, high cholesterol, joint pain and heart diseases. On reflection, it becomes apparent that menopause and the SRH of aging women is

completely omitted from Afghan National RHP and health practices and it is also not registered on people's consciousness as well.

In conclusion, the unfortunate facts and evidence from over the entire life cycle show that women die from pregnancy and childbirth related complications, lack of access to health facilities and honour killing (the United Nation MDGs 2013, 2014, 2015 and Zeid, S. et al., 2015, WCLRF and OSA 2015, WCLRF 2009). A complex array of factors impact on SRH service uptake nationally and on an individual level. How these factors play-out in the lives of individual women over their life cycle is shown below in figure (11) followed by a summary of recommended interventions (Table 13) in short, medium and long-term propositions at individual level.

Figure 11. Summary of Factors Impacting on Health of Afghan Women Over Their Life Cycle

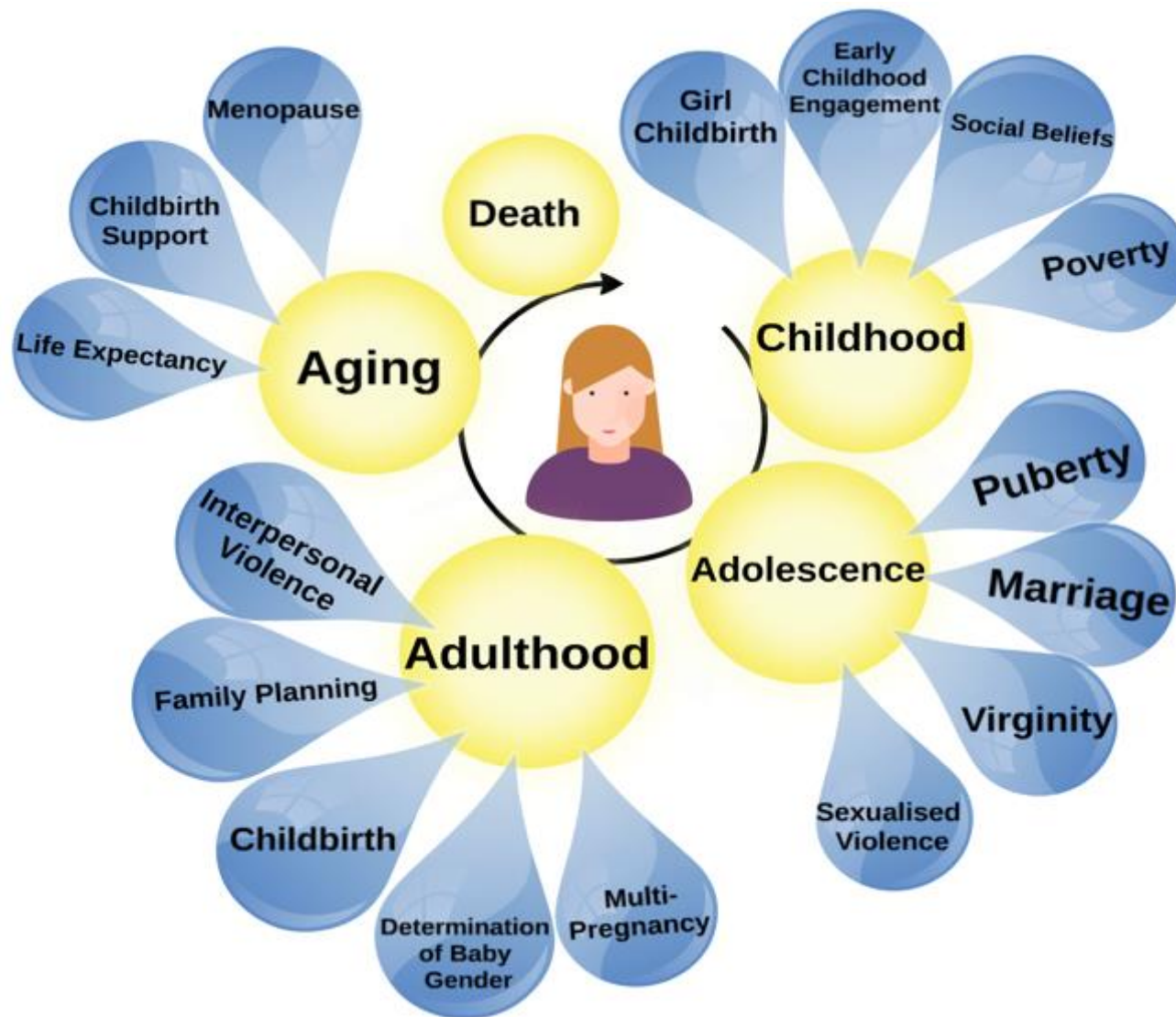


Table 13. Summary of Recommendations at the Individual Level:

Individual Level	Interventions	Short-term Actions	Medium-term Actions	Long-term Actions
	Age-appropriate, Culturally Acceptable Comprehensive Sexuality Education (CSE)	There might be some resistance in short-term scale - Increase SRH awareness for those adolescents who have access to education		
	Free Contraceptive Distribution	- Help women in remote area who cannot afford contraception or might not have access to HFs - Reduce fertility rate		
	Involvement of Men and Civil Society	- Religious leaders role is crucial in terms of SRH awareness - Encourage community participation		- Improve communication - Reduce SRH sensitivities - Increase women's honour at the household level - Delay young age marriage
	Supplementary Food Distribution during pregnancy and post-childbirth	- Poor t women particularly in rural areas can benefit from supplementary food consumption - Improve the health status of women who suffer from malnourishment and anaemia - Encourages breast feeding		- Improve health and well-being of women - Reduce SRH complications
	Financial Empowerment Through Vocational Trainings	- Income generation - Financial independence - Women's financial support to husband		- Reduction of dishonour and violence - Increase in power of decision making - Increase value to women's opinion - Reduction of household clashes while all women are busy in vocational trainings - Reduces Poverty and financial dependence
	Mobile health (m health)		- Distribution of free mobile phones to each household in rural areas - Technology-based sexual and reproductive health interventions via smart phones increases SRH awareness among men and women - Text messages could aim to reduce maternal mortality and morbidity - Connect individuals with CHWs and local HFs	- Save lives - Break down of some unhelpful practices - Change parents perception around SRH communication - Increase conjugal communication - Change SRH seeking behaviour - Provide guidance for public and private health sector partnerships and between mobile network operators

Summary

In this chapter we have discussed the negative and positive experiences of women during their childhood, adolescence and adulthood. Lack of knowledge and poor communication between parents and children particularly girls, husbands and wives and daughters in-law and household members clearly have a profound impact on women's SRH service seeking behaviour and knowledge right across the life cycle.

We learnt that in a war affected and male dominated society, Afghan women, particularly those of childbearing age, face heavier risks to health than men. We also explored the roles of members of the family particularly the husband and in-laws in influencing pregnant women seeking towards either institutional SRH care services, more traditional SRH care or only family based care.

Women usually do not possess the rights to plan and discuss about their pregnancy or visit a health facility for health check-ups or obtain contraceptives. Research participants mentioned that they had to seek mothers-in-law's permission before seeking their husband's agreement on going to a health facility. When they do try to access care (often by deception). My data revealed that over 100 female participants found this difficult accessing health facility. Many women went to the health facilities from a distance of at least 30-120 minutes walk. This may not seem much but it is dangerous given the instability, insecurity and the attitude to women being seen out in public.

My research mainly suggests that coerced and unsafe sex, especially during pubescence, periods or post childbirth, is fuelling violence against females and increasing STDs and mental illness among women. According to the examples some women after marriage lost their value and identity in various ways including, being called by many abusive names. In the Afghan context, verbal, behavioural and physical violence is commonly practiced and accepted in the society and household. A large proportion of women I spoke to were subjected to all sorts of violence.

Finally and unfortunately menopause is not addressed within policy or health facilities seemingly because the majority of women die before old age.

Chapter Eight

8. Challenges At the Health Service Provision Level

Health Service Providers (HSPs) play a significant role in the provision of higher quality SRH services (Abdel-Tawab 2002, Speizer 2000). As some of the preceding quotes suggest, communication around SRH is not only constrained in the family and social milieu, but also extended to the health care provision level. This chapter explores the main factor behind poor levels of communication, knowledge and uptake of SRH services.

8.1. Impact of Overcrowding and Workload on Higher Quality SRH Service Provision

As observed at four health facilities, patients tend to go to public health facilities to obtain free health care services due to their poor economic status. Due to overcrowding, patients however may not have a chance to access to the health services on the day they attend and share their health issues with the HSPs. In the Out Patient Department (OPD), In Patient Department (IPD) and maternity sections, HSPs were often overwhelmed filling in forms and patients' record sheets. When patients tried to discuss their health issues with the HSPs, their health conditions were often overlooked. For instance, in ASB district hospital, on a daily basis, around 200-400 patients wanted to obtain a visiting card. However a large proportion of these patients had to return back home empty handed. HSPs were often busy doing paper work. The paperwork consisted of filling tally sheets, vaccine sheets, and patients' files, discharge sheets and identification cards. Midwives usually do the paperwork along with the vaccination of mothers and babies.



Photo 21 a & b. Paperwork in ANC and PNC sections of ASB/DH

According to my observations, in the ANC (antenatal care) section of ASB/DH, two midwives were usually busy with routine practices. The first did patients' physical check-ups, which involved manual examination of pregnancy length and weight measurement however the blood pressure was not usually monitored. The second midwife filled in the forms while she also doing Haemoglobin and urine protein tests. They usually attended to two women at the same time and sometimes due to overcrowding they even attended to three patients simultaneously. Likewise, in the PNC section, two midwives were routinely attending two post-partum patients, plus one for the application of IUD, dressing of C/S sutures or Depo Provera injection in the procedure section (Photo 24, the corner to PNC room behind the blue curtain).

Conversely, in DB/ DH, one gynecologist and one midwife usually attended patients but frequently provided minimal physical examinations. The midwife completed the tally sheet and patients' records as the doctor prescribed medicine. I often observed the doctor and midwife hurrying because they wanted to leave hospital before 12:00 p.m. Therefore, they only attended patients from 9-10:30 a.m. and those patients who arrived later than this missed the chance to have a doctors consultation.

Routine procedures were also observed in both Comprehensive Health Clinics (CHCs). In each there was only one midwife who was responsible for the physical exam and recording patients' visits, but each include no blood pressure and weight measuring appliances and urine or hemoglobin test facilities. This is not a new problem. A study by Khorrami (2008) in

Rabia Balkhi maternity hospital in Kabul ascertained that 54% of the participants' blood pressure checks and proper health checkups were not done during pregnancy. A Focus Group Discussion with ANC section midwives revealed why patients' health issues are overlooked. Midwife (277) said:

"We are busy registering and filling in patients record sheets. If we follow the rules and take a complete history of at least 10 patients the first time they attend, we may not have time for other patients. We do not have the time to practice or talk to the patient. A few days back they reduced the number of ANC patients to 50 per day, which is still high. If we really follow the rules we will not be able to attend more than 10 patients."

Midwife (278) said: "It is very difficult to listen and talk to everyone. At first there was one midwife. Since the Dipstick Protein test was introduced (usually infections, blood or protein in the urine sample of pregnant women are detected and tested) we are two midwives."

The discussion indicates that HSPs link their lack of communication to paper work and a shortage of time. They claim that writing patients' histories in tally sheets, finding patients' visiting record sheets from the drawers, testing for Haemoglobin, Protein urea and other infections and physical exams are time consuming. Therefore, they lack the time to listen to patients and communicate with them properly.

In addition, the FGDs between midwives indicate that HSPs do not have knowledge of the other sections' work procedures and disregard patients' records from other sections.

MW 277: "In the maternity section, the ANC record sheet has no value."

MW 278: "When I was in the maternity ward, I used to ask patients "do you have an ANC card? They were telling me yes or no. I was telling them okay. I used to disregard the patient's recording sheet and made my own sheet with the new history of patient. I never checked what is written on the ANC record sheets."

The issues of paperwork are partly a matter of design or format. One of the health officers (198) at the ASB/DH in responded in this way:

"In each section of OPD (ANC/PNC/ FP) we reduced the number of patients to 50 in a day. Each patient can have a 10-minute visit, which is sufficient to discuss her health issues and obtain health care services. We recently designed these sheets for patients' records. This is time consuming, but we just started this procedure. According to quality assurance and

Basic Package of Health Services (BPHS) we started a new design. In other hospitals, these sheets are not available.”

This is an effort to introduce best practice (or at least BPHS requirement) but it appears not to have been thought through in terms of what midwives may need to know about how routine care (ANC/PNC/ FP) links together organisationally. From observations of the various maternity sections of the district hospitals it was clear that HSPs, mainly midwives, did not maintain patients' records. HSPs did not inform patients about the importance of the visiting record sheets, especially when a pregnant woman had carried to term and would give birth in a few weeks. The head of a district hospital (222) during an interview discussed similar issues,

“We allocated 50 patients to ANC / PNC sections 25 in the morning and 25 in the evening. Health care providers have more time to spend with patients. They have 8 minutes, but they are careless and never know their responsibilities. This is unkindness to patients. God shows them the right path! Otherwise, according to our assumptions, HSPs during 8 minutes of time can record the history of patients in a sheet. When a health care provider does not take the history of the patient and does not properly communicate with her, how can they provide proper health services?”

The quote indicates the head of DH reduced patients' visits from 10 to 8 minutes. In addition, it appears challenging to know where the blame/ fault lies? Is it the midwife fault for not knowing their responsibilities and/or not practicing them? Is it the responsibility of the DH head to educate the health staff, especially midwives about organisational structure, procedures and routine practices and to ensure these are enacted / practiced?

These observations indicate that overcrowding, workloads and poor routine practices impact on communication between patients and HSPs. Therefore HSPs miss the chance to fully understand patients' health issues in order to provide proper health services.

8.2. Communicating SRH Check-ups and Treatment Procedures

Health care providers failure to provide information, follow standard procedures and listen to patients' health issues means patients are continually un-informed. For instance, I observed a pregnant woman (8), in a district hospital, who asked HSPs several questions.

"I am pregnant. I did this test when you wanted to check my pregnancy."

HSP1 (277) did not reply. The woman asked again. "Do I really need to bring my urine?"

HSP1 said, "yes."

After her urine was tested the midwife wanted to take her blood for haemoglobin level test. She was looking confused and asked again, *"Does my blood show that it is a boy?"*

HSP 1 said, "You ask a lot of questions. It is better to be quiet. I write the reports on to your card."

To perform the physical exam, HSP 2 (278) asked the patient to lie on the table. She lay down without taking her shoes off. The HSP got annoyed and said, *"When will you learn to take your shoes off? Get up."*

The patient had to leave without being physically examined. After she left the HSP (278) said:

"I do not know how to teach patients about the procedure for ANC visits. If you ask the patient stand on the weighing machine, she stands on the glass of the machine with her shoes on. Think about it! We become mad telling patients about these things everyday. There is another problem. When we give them the container and ask them to bring in their urine sample, they say we brought it last time so why should I bring it again."

The conversation shows the extent of the HSPs frustration with patients. Instead of informing patients about the ANC examination procedures, they tend to overlook the basics and even insulted a patient who forgot to take off her shoes. Such frustration could be due to the overwhelming number of patients or the lack of appreciation by senior staff for junior staff work. Since senior health professionals (health officers, health advisors, manager) observe the tally sheets and patients' recording sheets, HSPs complete documentation diligently and never want to make any mistakes. However, diligence with paperwork

distracts them from communicating with patients and giving more attention to the patient's needs. Another example from participant observation (60,61) highlights the issue clearly.

HSP (60): "Give me your finger. Uff! (Exhaustion) Why are you such a stupid woman? When I ask you to give me your finger, you did not understand and give me your entire hand."

Pt (61): Smiling. "Sorry I do not understand."

HSP 2 (62): "Hurry up and go lie on the table."

The patient took her sandals off and lay on the examination table. HSP2 checked her pregnancy length manually and told her "Finished".

Pt: "Do you want to check my blood pressure"?

HSP2: "The blood pressure machine is broken."

Pt: "I have been itching and I have watery discharge. I cannot even sleep properly. Please give me something so I feel relief."

HSP2: Busy in filling the tally sheet. Patient continues:

"All night I cannot sleep due to itching. Can you give me some medicine"?

HSP1: (with anger). " 'Khwarak' (sister) There is nothing in your urine test results. You are healthy. Drink water and you will feel better."

HSP2: "Hurry up go and leave the room so that we can attend to other patients."

The patient only obtained 40 Iron tablets and left the room.

Repeated observations revealed that important health issues of patients are routinely overlooked. Even when patients ask for blood pressure monitoring or complain of headaches, their blood pressure is not monitored and physical check ups are not done properly. On a daily basis, I observed more than 10 patients leaving the health facility empty handed. One of the midwives (281) discussed the reason they overlook patients health demands during a focus group discussion.

“So, how many patients shall we talk to about their health issues? If we sit with patients and talk to them it takes time. It limits the chance of other patients to visit us. We can only hear their health issues but we are unable to solve all the patient’s health problems.”

Health service providers do not deny that they overlook patients’ health issues. It seems that HSPs regularly, tell patients off for being ignorant and for not understanding their next visit dates. However HSPs add to the problem by not making everything clear to the patients. Similar issues were discussed during a focus group discussion with Gynaecologists and GPs. They expressed their concerns over the lack of adequate communication and mutual respect between health providers and patients.

MW (285): “Due to overcrowding many patients miss out on the chance to have ANC/ PNC visits. When they come to the ANC section, they know that they should come back next month however many patients are uneducated and they do not understand. The HSPs do not tell patients when to come back or when their next visit is.”

(287): There is a problem that HSPs ask the patient to come when they feel the movement of the foetus. If a woman does not feel the movement of foetus shouldn’t they come still for an ANC appointment?

(285): Even if patients do not know the movement of the baby should come and request HSPs for the check up but unfortunately they are not examined properly. Some patients come from ANC/ PNC section and when I check their BP (Blood Pressure) there is difference in my BP check and other sections report. Actually, it is not the HSPs fault. Due to the crowd, they cannot talk to patients for long and do not give them a date for their next visit. There is only one ANC room and loads of patients.”

(287):” Most patients come here and say “In ANC they told me that my baby is not moving.” I do not know if they have a Doppler or a fetoscope. A few months back a patient came to me and said, “My baby died in my womb but the midwives did not tell me.” Her foetal heart might not have been heard or they did not tell the patient.”

The discussion between gynaecologists and GPs indicated that, despite the overwhelming number of patients and paperwork, HSPs try to fulfill their duty and visit patients. Data from routine observations of health facilities indicated that HSPs, mainly in ANC and PNC sections prioritised paperwork over patients’ health issues. They do not consider the consequences of such acts because their lack of knowledge around SRH issues and

health checkup procedures not only impacts on patients' health seeking behaviour but also creates numerous challenges for the HSPs.

Some participant observation notes also indicate that HSPs impose their own beliefs on patients and are not willing to properly respond to patients' queries. I observed a mother-in-law with her 18 year old daughter-in-law (291, 292) She had a newborn baby. She was worried about not getting pregnant again. Her mother-in-law asked the midwife:

“Mother-in-law (291): what method of contraceptive is good for my daughter-in-law?”

HSP (164): “There are many types of contraceptives which one do you want? How many children do you have?”

Daughter-in-law (292): I have a newborn baby.

HSP: Ohhh why? At least have more children then think of contraceptives. It is not good for you to use contraceptives at such a young age.

Daughter-in-law (292): (looking surprised). I do not want more children for at least 3-4 years.

HSP: Bring some children in to the world and then stop getting pregnant.

Mother-in-law (291): Okay. Then what should men use?

HSP: Ask your son to go to a male doctor and obtain information.

Mother-in-law (291): Why don't you tell me?

HSP: Men know men's work. We can't say anything.”

Daughter and mother-in-law were looking at each other and then they had to leave the FP section. This quote clearly indicates that the HSP is imposing her beliefs on patient by giving her subjective information and telling her and her mother-in-law what their values and practices be. In addition, some HSPs refuse to talk about condom use for men. If HSPs themselves believe that SRH is only related to women, it is a challenge to change the perceptions of local people. I also observed that HSPs usually do not explain the positive and negative effects of contraception to patients unless they ask about it. Even when explaining the advantages and disadvantages of contraceptives, HSPs usually promote the method of their own choice.

The quote shows that, contrary to many of the quotes in chapter 7, some husbands, wives and in-laws do communicate about contraception. However the HSP's refusal to discuss contraceptive methods prevented this particular couple from obtaining contraceptives, at least in this instance. Conversely, an HSP (360) in one of the Comprehensive Health Clinics voiced a different perspective.

"We should leave the choice of contraceptive methods to patients. However some HSPs usually select a contraceptive for patient and never give them a chance to choose their own contraceptive method. I ask patients if they have obtained the permission of the husband or in-laws. Some women say their husbands are not aware. Some say their husbands do not like condoms." Patients prefer injections so no one at home notices that they have obtained contraception."

From these routine observations, it appears that HSPs judge patients by their age and number of children, and then offer a particular method of contraception to patient. Moreover, patients who demand particular types of contraceptives do not receive adequate information about the impact and side effects of contraceptives. For instance, if a patient receives condoms, HSPs do not explain condom use and are not willing to tell patients that they should return to the health facility to obtain an emergency contraceptive pill if the condom ruptures. Only in one of the FP centers, I did hear midwives telling patients about condom rupture and need for emergency pills.

This type of conversation makes patients conscious of condom rupture and use of emergency pills. However if the condom ruptured on Wednesday or Thursday night the patient might not have a chance to obtain emergency pills because health clinics are closed on Thursdays and Fridays. Therefore, such unwanted pregnancies may occur. HSPs do not provide counselling or medicine to women who want to abort their baby, resulting in those women taking three or four oral contraceptive tablets in one go in order to induce bleeding and abortion. Many times during my observations HSPs refused to support women who wanted to have an abortion. During an interview one of the midwives (215) said:

"Women try many ways of aborting their babies but why should we be part of their sin?"

This research shows that HSPs do not explain the possibility of birth complications to the pregnant woman or her family members. Let's learn more about Habiba (17) who gave

birth to a baby daughter and asked me to adopt her baby. She was very depressed about giving birth to a daughter, but also she was unable to move due to severe pain. She was complaining about burning and pain:

“Ufffff! (Exhaustion) I have a very bad pain. I cannot move. One of my feet is numb. There are young girls (midwives in labour and delivery rooms) they are very unkind. I wanted them to help me while I had childbirth pain, but they did not hear me. During my labour and delivery, they checked my body (vagina) more than 10 times. They pushed inside to break my water. My body burns I cannot pee. I think they tore my body (she had lacerations and felt burning during urination).”

It is evident that the midwife, without seeking her consent, examined her and ruptured her membrane in order to speed up delivery. I quickly understood that Habiba had lacerations but the HSPs did not repair it, or even if they sutured the laceration, they did not tell her about it. Such experiences were observed routinely in district hospitals; HSPs often avoid sharing any information with patients.

Similar to other contexts (Sariola & Simpson 2011, Kirkham 2000, Green 2003, Essendi 2010) the research data reveals the extent of miscommunication at the health facilities between health care providers and patients. In addition, most of the health care service procedures were not discussed with patients. Communication and knowledge transfer to the patients and their family members' needs to be done carefully because a lack of information or misinformation might lead to misunderstanding and interpersonal violence. For instance, a midwife (265) in a district hospital shared her experience of miscommunication with the patient's family.

“I told them, she is not pushing and she will kill the baby (rather than saying the baby will die due to the foetal distress). The patients' sister in-law heard that and eventually she gave birth to a dead baby. Her sister in-law told everyone that she killed that baby. Her in-laws and husband hit her a lot. She came two weeks after childbirth and had cyanotic (patchy skin) on her body due to recurrent beating.”

This quote demonstrates that mis-communication around reproductive health can result in many additional issues. Those participants who experienced mis-communication with HSPs suggested that in order to obtain patients' trust and convey proper information, HSPs could at least explain physical examination procedures, or any health complications to them and their family members.

Interviews and discussions indicate however that a small proportion of Hazara and Tajik families were aware of the ANC visits and FP methods because these participants had experience of ANC and FP service uptake in neighbouring countries, especially Iran.

I observed numerous cases of pregnancy complications and repeated infections among those patients who had less or no information about SRH and relied on traditional remedies. Some HSPs acknowledged the need for knowledge transfer mainly around genital hygiene as part of health checkups and treatment procedures. For instance, a gynaecologist (293) who was working in OPD section of a district hospital said:

“Due to overcrowding, I do not have sufficient time to talk to each patient and inform them about the necessity for health checkups, sexual organ hygiene and harms of unwanted medication during pregnancy. Many women who come with cervicitis, PID (Pelvic Inflammatory Diseases), pyuria (white blood cells or pus cells in the urine), dysmenorrhea and infertility do not pay enough attention to good hygiene. Their husbands do not take part in the treatment. That is why our medication is not effective and women suffer from recurrent STIs. I just did a vaginal check for a patient. She was very dirty. I was feeling bad during the examination I thought I should ask her “Why are you not taking care of your intimate parts and keeping them clean?” “Then, I felt shy to tell her? Some patients, even during childbirth, insert animal dung (into the vagina as a home remedy) and that causes infections. This is not only a problem for us, but also the patient will not recover even if she takes antibiotics. Some patients never wear knickers even when they have periods. All the blood goes onto their pajamas. I ask myself how they will be cured?”

According to this gynaecologist, a large proportion of patients suffer from STIs due to a lack of knowledge around hygiene. According to her, a large proportion of women due to poverty and lack of knowledge about hygiene do not even wear under-garments. This suggests that even this gynecologist is relatively ignorant about the causes of STIs.

Given their ages and small body frames many of these women are perfect candidates for obstetric fistulas. Some of the symptoms that HSPs are talking about with reference to poor hygiene actually could have been due to fistulas, but they are not properly checked. In addition, according to the doctor, many husbands do not support patients with fistulas. If the HSPs want their husbands to be treated as well, patients hesitate to communicate about her health issue with husband and seek his support for joint treatment. Another issue was the absence of the husband while women visit HSPs for treatment of STIs/ PID. It is not socially acceptable for men to accompany their wives inside the health facility. Those men who accompany their wives have to wait outside the health facility.

Some women, particularly from nomadic ethnic groups do apply sheep dung to their vaginas to ease home-based childbirth. If the nomadic women suffer from childbirth complications or retained placenta their families take them to the health facility. HSPs who observe dung in the vagina of patients are harsh and abusive about dirty or stinky vaginas.

Exceptionally, there were a number of health promoters in one of the district hospitals, which was supported by MSF (Médecins Sans Frontières). However in another public district hospital and two comprehensive health clinics there were no health promoters to convey sexual reproductive messages to women. The health promoters convey health messages to patients and their companions in the hospital and within the local communities. However, there has not been any substantial improvement in women's SRH understanding. A number of midwives in the ANC/ PNC and maternity sections of the MSF supported district hospital (277-9 & 281-3, 305-8) still expressed concerns over patients' lack of SRH knowledge about hygiene.

“Some patients are very stinky from head to toe. Their vaginas are very stinky. They smell of urine. My colleagues were doing a physical exam, when the patient lay on the bench. They were about to faint from the smell. We suggested numerous times that health promoters should talk to them about their body hygiene. When health promoters, however, talk about hygiene, there is a need to speak clearly. I do not know if the patient ever hears or whether the main SRH issues are not clearly discussed with them. I talk to patients. However, it is not my job to talk about their health issues, and especially those health issues related to the lack of hygiene.”

One of doctors (285) during an interview in ASB/DH suggested practical way for improving patient knowledge. She believed that if health providers spend sometime with their patients and listened to their health issues, many problems will be solved. She added:

“Here because it is overcrowded I cannot talk to patients properly. In my private clinic, I spend time with patients. I know that they have their specific problems. If we do not counsel and explain issues to patients properly, there will not be any positive change in people's perceptions. We know over 80% of Afghans are uneducated.”

Increased provision of more health promotion alone is not necessarily the whole solution, as in remote districts of Kabul city, where mobile health promoters do convey health messages related to pregnancy, childbirth and hygiene, many women felt reluctant to

discuss their health issues in front of other women. If they suffered from a serious health issue, they had a tendency to talk to the female health promoter in a place where other women could not hear what she was speaking about. Indeed, some women mentioned that the reason for hiding their health issues was due to their fear of loss of honour and trust within the household or humiliation for being unhealthy. A health promoter (308) shared her experience,

“Many patients wish to discuss their concerns related to their SRH issues. I always talk about hygiene. I do not know how they are alive. I think if I drop one tank of water over them they will not be cleaned. The main message of health promotion topic is for parts of the body hygiene that people never consider. Many women ask me a lot about irritation to their intimate parts, discharge and itching. However they do not wish other women to know about her health issue. Since my supervisor is a male, I could not ask him how to inform women about their SRH issues properly. Women say we use home remedies that makes the vagina cold. Might be menthol, but with no effect. They separately said, when we itch, it bleeds from scratching and looks like a red piece of clothing. I did not know how to answer.”

I asked her how difficult it is to explain many issues related to sexual health? She said:

“Women usually cannot talk about their private parts and health issues in front of other women. They usually talk to me in private, but still feel shy. A patient asked me about itching and discharge during her second pregnancy. She said:

“In my first pregnancy, I was suffering from the same issue, but I could not tell anyone and I was feeling shy.” I only told her to wash the intimate part with soap and water and drink water because she was pregnant. She said, “I washed, used gentian violet and cream, but it did not work.”

The health promoter continued, *“I think washing the vagina with water does not solve the PID, UTI or STI issues.”*

This quote shows that some female health promoters could not properly discuss SRH issues with their male supervisors to seek their advice. Equally important, however is that male health officers prepare health promotion curriculum for women and they usually avoid raising sensitive SRH issues. It is important to consider that HSPs and health staff are also

members of traditional Afghan society. Professionally they have a duty to provide health awareness to patients and help patients with their SRH issues however they are constrained by their cultural norms from doing so.

8.3. Linguistic Barriers

In Afghanistan two national languages 'Dari' and 'Pashto' are commonly spoken. In all 4-research sites, a large proportion of HSPs were Dari speakers. However many patients, especially in the Eastern districts of Kabul city are Pashto speakers. Observational notes indicated that HSPs in a FP section of a district hospital disregarded the opportunity to use flip charts to help patients understand contraception. I had a chance to take pictures of the flip charts, as the HSPs left it on a cupboard and did not use it. In answer to a question about why they do not use the flipcharts, a midwife (86) answered:

"We do not have enough space on our table to put it and we don't have time to talk to each patient. There are some photos which I feel too shy to show to my patients and talk with them"

These are the pictures of the FP decision-making tool in Dari and in English language. The English version was copied from WHO FP decision-making tool (2005).

Photo: 22 Dari and English Version of Family Planning Decision-Making Tool





Let's consider your risk

- Some situations are more risky than others — such as having more than one sexual partner
- Often, you may not know if you or your partner has an STI or HIV
- A person with HIV can look and feel healthy
- If you are unsure of infection, tests may be available



Some STIs have signs and symptoms:

For a WOMAN

- Pain in your lower belly?
- Sores in or around your vagina?

For a MAN

- Pus coming from your penis?
- Pain or burning when you urinate?
- Open sores anywhere in your genital area?



Comparing methods

<p>Most effective and nothing to remember.</p> <p>Fewer side-effects, permanent:</p> <p>Female sterilization Vasectomy</p> <p>More side-effects:</p> <p>IUD Implants</p>	<p>Very effective but must be carefully used.</p> <p>Fewer side-effects:</p> <p>LAM</p> <p>More side-effects:</p> <p>Pills Injectables</p>	<p>Effective but must be carefully used.</p> <p>Fewer side-effects:</p> <p>Male and female condom Vaginal methods Fertility awareness-based methods</p> <p>IMPORTANT! Only condoms protect against both pregnancy and STIs/HIV/AIDS</p>
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Photo: 23 Dari and English Version of Family Planning Decision-Making Tool

Photos 22 & 23 clearly indicate that the messages were adapted from WHO FP decision-making tool (2005) with slight changes. While there has been some effort to try to make the FP tool useful, it appears to have been a complete waste of time. I inferred that the real problem was depiction of condoms and male genitalia.

Moreover, the flipcharts was translated from English into Dari language. In this particular district hospital the majority of patients were Pashto speakers. Thus, even if the patients were literate in Pashto, they could not read the message, as the poster is unintelligible to them. The flip chart is unsuitable in terms of language and social customs.

Moreover, I noticed two other main points. First there was a picture of a couples obtaining contraceptive methods guidance from a HPS. In an Afghan context men are not allowed to enter maternity health facilities and there is no FP counselling for couples. Second, the flipchart stated that HSPs assure the couple about confidentiality. However according to my observations, patients' confidentiality was not considered and HSPs were attending and counselling 2 -3 patients at a time in one open room in order to see the queue of patients quickly. In addition, the IUD or injections were also applied in the same room. On a whole range of levels these diagrams are not sufficiently explanatory. The flipcharts do no convey any useful message for those who are illiterate. Usage of these flipcharts would result in many misunderstandings and further problems.

I would like to share a few examples of how communication between HSPs and patients also broke down for linguistic reasons. The mainly Dari speaking HSPs had trouble explaining IUDs insertion procedure, especially in the Pashto language. An example of such difficulty is:

“Saman dakhil nashi se raqam kawoo” (This Pashto sentence does not mean anything due to the wrong Pashto wording. The midwife in the family planning section wanted to tell the patient that if her cervix was closed the IUD couldn't be inserted).

In the ANC section a midwife (61) said:

“Haiwan de khogigi?” (Means Baby pains? She intended to ask if the baby moves in her womb. She could have asked *“Haiwan de khoazigi”* means does the baby move?)

Another example in PNC section occurred when midwife (116) was explaining oral contraceptive uptake in broken Pashto.

“De bel mashomano vaccine shi”! ? The midwife was supposed to ask, has she ever had a vaccination during her pregnancy or after childbirth? However, in this sentence she asked about ‘children vaccination’.”

Some midwives admitted to language barriers hindering communication with patients and understanding their health issues. The midwife supervisor (265) in a district hospital mentioned that health staff couldn't communicate properly with some of the women who came from remote areas.

“Even among Hazara communities there are some people who use words that midwives do not know. People's dialects are unique and it is difficult to understand their language unless you live among them and work within them for a long period of time. For instance, Hazara patients used to say ‘Kiil’ and midwives were wondering what “kiil” means. After a long time they realised that patients meant to ask if the baby was lying in a transverse position. Other Hazara women were saying ‘pisht Chabin dard mona’ and none of midwives knew what this means. They ask the patient again and patients described that it means she has pain in the lower pelvic area.”

There were a number of health promoters who could only speak in Dari and just memorised a few sentences in Pashto. For instance, a health promoter who was a Dari native speaker (311) shared her language problems during health awareness sessions.

“Since I am a Dari speaker it is difficult to speak Pashto while travelling to remote areas where Pashtons live. The only challenge is the language problems. When I talk to Pashton patients they sometimes do not know what I say. I go and ask my colleagues if they could come and talk on my behalf. People know that I am not a Pashton and they were laughing at my language. It is good that our training materials are in Pashto so I can learn and memorise health messages from those charts and materials.”

This is a contrast to the material in the DH / CHCs, which were mostly in the Dari language. It is important to note that language barriers not only lead to communication gaps between HSPs and patients, but also between HSPs and senior health staff. For instance, an international gynecologist in one of the district hospitals (128) was trying to explain a patient's health issue to the national HSPs. She wanted the HSPs to interpret the information to the patient. The midwives and patient could not speak in English. The national doctor and one midwife could speak enough reasonable English to translate the patient's complaint. However, the midwife only interpreted a few things from many health complaints of the patient. The patient was newly married and had bleeding. Her vaginal

area was swollen and tender. The international doctor (after vaginal examination) told the national doctor and midwife to tell the patient to buy some lubricants or gel to make the area moist in order to feel comfortable during intercourse. The national doctor and midwives were shy. The doctor told the midwives:

“You tell the information to the patient.”

The midwife replied to doctor: *“ You are senior and know more than me. Please will you talk to the patient.”*

The international Doctor asked the HSPs *“ are there some lubricant or gels available in the drug stores”?*

The national doctor said, *“ Well, I do not know”* with a smile while her eyes were sticking to the ground.

Midwife, *“I do not know either, but she can use paraffin.”*

Finally, after two minutes of silence the midwife told the patient,

“Use paraffin before sleeping so that makes the area soft and you will not feel itching and pain.”

The main issue however was pain due to the rupture of hymen. The patient was in pain and scared of intercourse. She did not allow her husband to have intercourse with her for 3-4 days and after intercourse she had bleeding and pain. This communication problem had multiple causes. Firstly, although HSPs dealt with such patients on a daily basis they were not aware of the availability of gel or lubricants. Secondly, if senior health care staffs avoid talking about sexual health issues, how can we expect more younger or lower ranking staff to pursue this? Thirdly, how can HSPs expect understanding and knowledge from patients regarding the SRH issues? Fourthly, the language barrier exacerbated the chain of communication gaps between patients, HSPs and senior staff. As a consequence those patients who do obtain an opportunity to explain their health issues to the national and international HSPs often lose out on the benefits because their messages are not understood or not conveyed to international HSPs properly and /or international staff's messages are not accurately conveyed back to the patients.

8.4. Trust and Honour Between Health Service Providers and Patients

In chapter seven, the extent of trust and honour at the individual, family and community level was explored. Considering the interconnectedness of communication, trust and honour, it is important to assess the impact of these at the health service provision level as well. Trust and honour are connecting bridges between patients and HSPs. In other words, trust means relying on someone to provide factual information and respect confidentiality (Hawley 2015). Conversely the absence of trust and honour will diminish proper communication between HSPs and patient (Rogers 2002) and could also impact on medical relationships for health service uptake and provision. For instance Thom' s (2001) study examined the correlation of patient trust with HSPs behaviour in terms of proper communication, caring behaviour, listening and answering patients' queries and the capability of proper diagnosis and treatment. In contrast, the Afghan Mortality Survey demonstrated that lack of health resources and female HSPs could impact on women's health service uptake. In addition, it was noted that one fifth of female respondents expressed absence of trust between patients and HSPs, and this was one of the reasons that women did not seek health services (AMS 2010). Therefore it is crucial to understand how trust between patients and HSPs results in proper communication, health seeking behavior change and uptake of health services.

According to my research findings, a large number of HSPs claimed that the pressure of extra working hours, low income and overcrowd impacted on their behaviour and well-being. In addition, according to HSPs, their hard work was not acknowledged and appreciated by senior staff therefore they were not very enthusiastic about doing a really good job. Data from a focus group discussion with officials (317,320,328,329) at the health ministry of health revealed that the ministry staff believes that HSPs dedication to work and honouring patients and other health staff is lacking immensely.

My observations from the health facilities indicated that many women waited for hours to visit an HSP. Because the women were poor and not able to go to private health facilities, they had to put up with indifferent behaviour and dishonour from health workers. Even if women were verbally or physically abused they still would remain at the health facility in the hope of a chance to see an HSP. A pregnant Pashton woman (156) for instance, was waiting for her ANC visit. She was 7 months pregnant with her 10th child. She came from one of the remote districts. She was feeling breathless and flushing due to the crowd. She complained about the health staff's misbehaviour and abusive manner.

“I came here two times but failed to meet a doctor. I have to come because I feel ill and I am pregnant. The health staff insults us, pushes us back and calls us stupid and illiterate. My previous baby died at home because we did not have enough money for transportation and hospital expenses. I have to tolerate all the abuses in order not to lose my child again.”

Such stories circulate among women, and the overcrowding and misbehaviour of health staff discourage women from going to public health facilities. A number of HSPs complained about lack of hygiene. Other HSPs reasoned that it was a lack of knowledge about health facility visits and treatment procedures, which led to abusive behaviour and mistrust between health staff and patients. In one of the district hospitals, while women are waiting outside the door of ANC section, they are given containers to bring their urine sample for protein level and UTIs (urinary tract infections) tests.

During my participant observations in the ANC section (102) patients were asked to uncap the lid of the urine container and dip the paper stick into their urine. The midwife then took the paper stick out of urine container to check the level of protein. Although one midwife had gloves and had been assigned to perform the tests, she but did not do the dipstick test due to the strong urine smell.



Photo 24. Pregnant patient helps the midwife perform a dipstick test

Some HSPs complained about urine smells and others complained about the smell of sweat or un-clean clothes. I observed that a Tajik patient (107) after hours of waiting on a burning hot summer's day, had a chance to enter the ANC room. The HSPs told her that she is sweaty and it will not be possible for HSPs to perform her health check-up. The woman who was already was exhausted from a full day waiting outside in the heat, replied:

“ I took a bath but from morning I am waiting. At the hospital door, doorkeepers pushed me back many times. I was waiting outside for many hours in this heat. Obviously we perspire and we probably smell bad.”

Her reply led to a very big spat and the HSP was not willing to do her health check-up. This altercation took another thirty minutes to be sorted out. Other patients observing this ignored the humiliating behaviour of HSPs and kept quiet so that they would not lose their opportunity for a check-up. On a separate day, I observed a pregnant woman (109) being humiliated by a HSP. When she entered the ANC room, HSP (61) rudely shouted at her:

“Uffffff! (Exhaustion) wash your body and wear clean clothes. You smell very bad. You are very stinky”

The pregnant woman was just looking down at the ground and never replied back. I later saw her sitting in the corner of the hospital crying. She said that she escaped from home without her husband's knowledge because her husband did not let her go to the health clinic. She came to health facilities by walking and she sweated. She did not have money for transportation.

“With this clothes I bake bread, do house chores, and cook. I have no other clothes to wear to hospital. Even if I have clothes how can I change into them? Everybody in the house will ask me where I am going?”

This vignette shows that the HSPs' judgementalism, lack of respect and poor professional behaviour has a profound impact on women's poor health seeking behaviour. The comments that I witnessed were shocking in themselves but actually they could be even more devastating if these women who were blamed for a lack of moral or self-care were actually suffering from conditions such as obstetric fistula that were not properly checked, treated or managed.

Some HSPs unprofessional behaviour is not limited to insults, refusal of treatment or care. Even when HSPs do treat women their behaviour swings according to the appearance of the patients. Sometimes during their service provision they judge patients' ages, weight and blood pressure from their appearance and write from their own conjecture instead of trusting the information provided by patients. In the ANC section of a district hospital, a pregnant woman (37) with a pale and tired face entered the ANC room to have her health check-ups done. She was pregnant with her 4th child.

“Midwife (61): How old are you?”

Patient: I could be 18 years old.

MW: You look older. (She wrote 25 years old on the tally sheet).

MW: Where is your home?

Patient: My home is in{ name} but I do not know the number.

MW: you are a stupid woman. You do not know your age? You do not know your home address. Are you crazy? You only think life is to sleep with husband and get pregnant. Why don't you ask your husband about home address? You are an ignorant woman.”

The pregnant woman did not say anything because she wanted her health check-ups done properly. In another observation in PNC room, I observed a Pashton woman (289) with a unique name (although, her name might have been common in Pashton communities), HSPs were making fun of her.

“Midwife (116): What is your name?”

Pt: Paghoo

MW: What?

Pt: Paghoo

MW: Paghoo is a name? You should have another name. Hahaha! What does this mean?

Pt: I do not know. My parents gave me this name.

MW: What is your husband's name? Heyyyyyy 'Shatoo gul' (means shabby woman)

Pt: What? I do not know Dari.

MW: Ohhh, How old are you Dear Paghoo? (Asks in Dari) Hahahaha you kill me from laughing.

Pt: I do not know Farsi (Dari).

MW: How old are you? (Asks her age in Pashto).

Pt: I am 25 years old.

MW: oh. Are you joking? Do not lie. You are older. Stand on a weighing machine. (Dari)

Pt: What?

MW: Stand on the machine. (Pashto). The patient stood on weighing machine but did not take off her burqa and sandals and had a bag in her hand.

MW: how many KG? Humm. Oh okay 73 KG. I knew your weight before measuring it. I just wrote 70Kg here. No problem I count 3 Kg as your shoes, bag and burqa weight.”



Photo 25. A woman standing on a weighing machine in PNC section

This quote shows that woman's name was judged and humiliated. It is equally important to mention that such patients who do not speak Dari are often unable to discuss their health issues and when a HSP ask some questions they sometimes answer by either saying "Yes" or "No" and sometimes inappropriately. In addition, the health check-up procedures were inappropriately practiced and the HSP was reluctant to trust the information provided to her.

These incidents reveal that language barriers often provoke additional impediments to a good health care consultation. They also reveal that the cycle of abuse and mistrust, which observed in chapter 7, is not confined to the household. These quotes highlight that women, even at the health facility, can abuse other women by using devaluing and humiliating words. My observational and interview data suggested that a large proportion of women appeared pale, underweight and older than their age. The health reports of these women indicated that they mainly suffered from malnourishment, anaemia and infectious diseases. Some of these women made mistakes about how many children they had or

forgot their home addresses. Sometimes they complained about the loss of memory (amnesia).

Some research participants mentioned that due to the humiliating and judgemental behaviour of HSPs, they consume some un-prescribed medicine available at home or purchased from pharmacy instead of visiting an HSP. The research also shows that the intake of un-prescribed medicine during pregnancy caused many pregnancy complications. Many women facing health complications, especially incomplete abortion, bleeding or high blood pressure finally visited a health facility and did not clearly explain the actual cause of their health complications to the HSPs for fear of being abused or humiliated. When I asked patients why they hide unnecessary medicinal intake from HSPs, they gave different explanations. A patient (187) who had a caesarean section said:

“I got the flu and I took Paracetamol and other medicines available at home. The medicine did not work, so in my eagerness to feel better, I took some injections and two days ago my baby died in my womb. They operated on me and took the uterus out. I did not tell these doctors why my baby died. If I had told them they would not treat me properly and would have abused me more.”

A growing number of studies elsewhere have also examined women’s experiences of disrespectful and uncooperative health staff through their reproductive life cycle (Bowser 2010, D’Oliveira 2002, Small 2002, Silal 2011 and WHO 2014). Disrespectful behaviour discourages patients from SRH service uptake and increases the distance between HSPs and patients. Many studies also show that women who suffered from any pregnancy related health issues, depression or violence at the household or health facilities were unable to share it with any HSPs because their health problems were overlooked (Sarkar 2008, Ellsberg 2008). Despite the prevalence of such behaviour, observational data also indicates that some HSPs do behave kindly with patients. For instance, sometimes HSPs were giving a little money to patients after finding out that they are poor and cannot afford to buy food or fruit due to reduce their anaemia and malnourishment, or they were sharing their tea with some breastfeeding or pregnant women.

8.4.1. Family Planning and Lack of Trust and Honour

Another area of practice subject to distrust is family planning. HSPs usually do not provide any family planning support unless they see evidence of menstruations. I observed over 50

women who wanted to obtain IUD or Depo Provera shot but they failed due to a lack of evidence of menstruation. For example, a Pashton patient (86), wanted to obtain a Depo Provera injection. She asked for the Depo shot. The midwife asked her to show her some menstruation blood. The patient replied that it was her 6th day of period.

MW (88): "All women say the same thing. When you come to this room to obtain our advice, you must listen to us. If you have been bleeding we can provide tablets, injection and apply 'Saman' (IUD). If you do not bleed go home and wait until you have it.

Pt: Please give me an injection. I have 8 children and I am very ill. I don't want children anymore.

MW: "If you are that serious about not falling pregnant then why didn't you come here during your menstruation? If you are worried then use condoms.

Pt: My husband does not like condoms. He allowed me to use an injection.

MW (87): How do we know if you are pregnant already?

Pt: I beg you please do my pregnancy test and then get me an injection. I come from a very distant area. I did not have money for transportation so I walked. At the moment, I don't have energy in my feet.

MW (88): Do not give me a headache. Just leave and do not come here until you have your periods. We always check the bleeding first and then provide contraceptives. I cannot do anything for you. It is your own problem."

Despite the patient asking for a pregnancy test, which the midwife could easily have done via a urine test, the midwife refused to provide contraceptives. After the patient left midwife turned her face and said:

MW (88): "Many women lie. They are pregnant and insist on obtaining injections. I know very well what liars they are! They think these medicines will cause an abortion. Why should I be part of this sin? I understand their behaviour. If they suspect that they are pregnant, they come here and uselessly insist for some contraceptives."

Despite her embarrassment at showing her menstruation blood while other patients were present, this woman reluctantly took the cotton pad and went behind the curtain and smeared a sample of blood on it.

According to WHO/ HRP report (2014) such behaviour breaches patients' privacy and confidentiality. Considering patient's privacy and values are the foundation of proper trust and honour between patients and HSPs. In a small room of PNC/ FP patients' health check-ups, vaginal examination, contraceptive methods counselling, injections and IUD applications are practiced. Sometimes, despite other people being in the procedure room, patients just have to lift their skirts up and dip the cotton pad inside to show bleeding. Those women who failed to provide any evidence of bleeding did not receive any FP support.

Even when HSPs do understand patients' problems, they have their own rules and perceptions of health service provision. I observed a discussion between a gynaecologist and a midwife (164,165) in a PNC/FP section. The gynaecologist wanted to know the perception of the midwife around contraceptives provision.

“Doc: Many women get pregnant because they do not obtain contraception. Did any senior asked you to visit only those women who have periods? A patient said, that she wanted an IUD but because she did not have her period the midwife did not apply it.

MW: No. Usually patients lie. We give IUDs to women with bleeding.

Doc: When women have had 5 -9 deliveries you can apply IUDs even without any proof of menstruation.

MW: If patient is pregnant then contraception causes abortion.

Doc: It is good that they abort illegitimate pregnancy huhh. You can do a pregnancy test. No?

MW: Patients never tell the truth. It is so crowded sometimes that we do not have enough time to test for pregnancy.

Doc: So do you provide condoms?

MW: Huhhh yes we give them condoms and tell them if they rupture then come back!!!

Doc: Tubal ligation is good for this type of patient. You know yesterday I had 3 patients in the labour room. It was 12th, 11th and 9th childbirth with complications. I did not know which one to deliver first. All were eligible for tubal ligation and I did tubal ligation on all three.

MW: Yes. This is very important. They like it and ask as well. They will gain relief from various problems. I do not know what type of sin is there? Some people say it is sinful.

Doc: No. It is not a sin."

This conversation demonstrated that midwife did not have any scientific reasons to support her argument for not providing contraceptives to those patients who do not have bleeding. Conversely her perception shows the influence of social and religious beliefs on her practice and she did not communicate with the doctor fully about what she was practicing routinely.

During almost 8 months of my fieldwork in health facilities, I only observed one woman who asked for emergency contraceptive pills. The midwife gave her this tablet reluctantly. I also routinely observed that HSPs usually do not explain the positive and negative effects of contraception to patients unless they ask about it. Any descriptions in terms of condom use and precautions after rupture are avoided. Health service providers do not usually warn patients to come back to the health facility to obtain emergency pills if their condom ruptures.

Despite the conversation reported on the previous page, permanent contraception is banned at all public health facilities. The doctor (165) concerned was one of a few gynaecologists who was performing tubal ligation and advising other health service providers to help patients with this method of contraception. Most HSPs refuse requests for tubal ligation. It was observed in all four-health facilities that HSPs reacted harshly and prevented patient from requesting such 'sinful' contraception. Others sometimes referred patients to private health facilities.

8.4.2. Abortion

The United Nations Children's Fund (UNICEF 2011) annual report highlighted the fact that 2.5 million cases of unsafe abortion by adolescents under the age of 20 are registered in many low income countries. Since abortion is illegitimate according to legislative and Islamic jurisprudence in Afghanistan, this law exacerbates unsafe abortion and forces some women to experience lay practices. In many Afghan health facilities, any support for abortion is strictly denied. A number of women during interviews mentioned that to induce abortion they boiled fenugreek or the white flower of a Locust tree and drank the water in

the early morning on an empty stomach. Other women mentioned that they ate a full packet of oral contraceptives or anti-malarial medicine or even lifted very heavy objects, in order to abort the baby.

During my research, in one of the Family Guidance Centres (AFGA) in a maternity hospital, I observed a patient (209) who was pregnant with her 12th child. She was pale, underweight and young (26 years old). She began her periods 5 months after her marriage and then got pregnant. She also had two miscarriages. She asked the midwife if she could help her to abort her 12th child. The midwife replied:

MW (207): "Do not be upset. You worked hard to raise 11 children and now you can also put more effort in to looking after your 12th child. Even one night has passed during your pregnancy it is a sin to abort it. We do not have medicine for your abortion. God brings more blessings with new baby. Never think of abortion. It is a great sin to abort. Convince your husband to have this baby. This 12th baby will also be fed and grow up as others. Do not think of abortion. Now go home and do not waste your and our time."

The pregnant woman said, that her husband and her mother-in-law did not allow her obtain any kind of contraceptive so she gave birth one after another, and twice pregnancies delivered twins. The patient told the HSP that her husband did not want more children because they could not afford the extra expenses of another child.

MW2 (208): "I have three children and when I see these women I wonder how they look after so many children. Their eating, cleaning, schooling and many other issues even cutting the children's nails will take her a whole day. Hahaha. Complete 12 children so that would be "yak Tolai nafar" a dozen soldiers huhahaha. Go home it will be late... Hurry! Get up leave the room."

The midwives were making fun of her due to her multi-pregnancies. The patient was shy and worried. She begged them to give her some medicine so she could abort the baby. She was telling the midwife that it is almost two months since she started feeling pregnant. The midwife neither gave her a pregnancy test to confirm if she is pregnant nor provided her with any health or mental support. Although the patient had her husband's permission and had made an informed choice to abort her baby, she did not receive adequate support from the HSPs.

During a discussion with a gynaecologist and a midwife (297,298) in one of the comprehensive health clinics a patient (299) who was very weak and was walking slowly

entered the room at very slow pace she brought her baby in for vaccination. She came and said:

"Please doctor! Do my health check-ups and give me some painkillers.

MW: "Sorry time is up. It is lunchtime (It was 11:15 Lunch time is usually between 12-1 p.m.)."

Pt: "I am very ill. Two days ago, I had an abortion. Please I beg you. I am so ill I cannot stand."

Doc: "Two days? Is it a complete abortion? How could you come here?"

MW: "Two weeks after my abortion I was not able to stand up. How did you can come here?"

Doc: "Where did you abort?"

Pt: "At home."

Doc: "After two days could a woman walk to the clinic? Maybe you did not abort. How you could you bring your baby with you?"

Pt: "What to do? I have small children and no one to look after my children and me. I cannot walk now."

MW: "I hope you had a complete abortion and no particle is remained. May be it is your menses."

Pt: "I saw that everything came out. No it is clear to me, I abort it. Allah! I come here like a dead mobile body. What to do? I am not allowed to go out. My son needed a vaccination so for this reason I came out of the house and I want to take some medicine for pain."

Doc: "Abortion is so easy that by the second day you wander everywhere."

Pt: "No it is not easy. I die from pain and dizziness."

The HSPs gave her iron and painkiller tablets (Paracetamol). However they did not do any physical check up and did not monitor her blood pressure as part of other post-abortion care services. After the patient left the room, the midwife said:

“It is hard to trust patients. Some patients lie and never tell us the truth. There are some illegal abortions but how do I know she is telling the truth?”

The conversation demonstrated that HSPs hardly trust patients and are unresponsive to the need of patients. If a woman wants to abort a child she needs to have an approval letter from the MoPH and a doctors letter confirming that her health is in danger so health providers can abort the baby. According to Islamic clerics (255,257,258) if a mother’s health is in danger, or they cannot afford the requirement of a baby, woman can abort the baby with her husband’s agreement. They also mentioned that abortion before 120 days of pregnancy is lawful. Despite this, even if a husband and wife agree on abortion, restrictions on abortion at the public health facilities are widespread. Evidence indicates that many patients go to private clinics, take risks and pay high fees to have an abortion. However, those women who cannot afford the fees conduct self-induced or un-hygienic types of abortion.

8.4.3. Childbirth

Various studies have provided insightful assessments of the abusive and neglectful behaviour of HSPs particularly during childbirth (El-Nemer 2005, Bowser & Hill 2010, Silal 2011 and WHO 2014) Many interviews analysed the reasons women do prefer not seek out health services, especially during childbirth. During a discussion with women in one of the district hospitals, some Pashton women (39,40) were expressing their needs to have hospital-based childbirth.

(39): *“If you have money go to a private hospital. If you are poor like me, then you have to be patient and tolerate the abusive behaviour of health workers in public hospitals.”*

(40): *“But if you do not have any health problem it would be better to stay at home and deliver your baby with privacy.”*

Another Pashton woman (196) expressed her preferences for home-based childbirth:

“I think home is better for childbirth. Here the doctors were shouting at me. They did physical checks too many times. All women are mixed and it is not private. Watching other women, I forgot my pain. At home after three hours of pain I delivered my baby, but here I forgot my pain. The doctor asked me to walk. I gave birth to the child in the corridor and I shouted for help. By the time the midwife arrived my baby was lying naked on the bare corridor floor.”

During participants' observation at the health facilities, it was revealed that out of 124 female participants 75 patients put up with the harsh behaviour of health providers and avoid complaining at the health facility for fear that they might lose a chance to obtain proper health services and free medicine. Health providers' mis-behaviour, forceful rupture of membranes and lack of privacy make women want to give birth at home. I observed a number of patients who faced verbal and physical violence from HSPs during their childbirth.

A woman (135) stated that while walking along the maternity ward corridor she delivered her 6th child into her pants. She started shouting. A lady cleaner and a midwife brought her to the delivery room to cut the umbilical cord and discharge her placenta. Although, she gave birth in the corridor, she was happy that she did not face any harsh behaviour from HSPs because while she was in the labour room she saw the night shift midwives were beating women during their childbirth.

Another woman (136) who gave birth to her second child and was lying in bed was shocked to see how harshly HSPs behaves with her and other patients. She shared her experience after being admitted in the maternity section.

“Midwives behave very harshly. They shout and pinch patients. The midwife slapped me on my thigh and shouted at me to keep quiet and push. She said, “ Do not shout! You forgot this pain and enjoyed with husband now you have to suffer from this pain”

During participant observation, I was thinking how women face varying degree of obstetric/reproductive violence and how verbal, behavioural and physical violence could have a negative impact on patients' mental health and wellbeing. I heard a noise and a woman screaming (134). When I entered to the labour room a woman was screaming with pain and I saw the head of the baby was almost out. However a midwife came and started shouting at her:

“Wait! Wait! Don’t scream!”

When the midwife noticed that the patient had almost delivered her baby she took her hand and dragged her to the delivery room. Her feet were apart and she could not walk due to the protruded head of baby. However she had no choice about walking in that condition towards the delivery room.

Some women were comparing the pros and cons of home and facility based childbirth. They stated that they expected more caring and emotional attachment from HSPs during their labour and childbirth. Similar to the Afghan context, there have been a number of research papers on women’s experiences in Egyptian and Nairobi hospitals of being objectified and abused by health providers. In these studies some women complained about losing their freedom of choice such as, positioning on the bed, lying or walking along the corridor (El-Nemer 2005, Essendi, 2010).

The research shows that in the Afghan context, harsh and humiliating behaviour during childbirth is commonly practiced and approved. People readily express their disagreement or anger with abusive words and physical violence. During a focus group discussion with HSPs in one of the district hospitals (264-9), one of midwives said that the previous night they observed a husband’s abusive behaviour during his wife’s childbirth. She added:

“The patient came and she had time because her cervix was closed so we sent her back home. Her husband started beating her because none of the hospitals would accept her for the childbirth. He was beating her with fists in her back because no one would admit this cursed woman to hospital.”

She left to check if the family had brought that patient back to the hospital. She came back and said that the patient’s cervix is now 2 or 3 centimetres wide. The midwives’ supervisor asked the midwife to admit her anyway. Otherwise her husband would kill her due to the delay in her childbirth. I observed that HSPs did not explain the woman’s health condition to her family, especially to her husband. One of midwives started blaming the patient. She said:

MW (268): “Bala da pas ash Khob ash kard ke zadish’ (she was expressing her anger). Her cervix was still closed. Go to hell, her husband did a good job to beat her ahahah Why is she not coming on her time. Why she does not know her pain? If I were her husband, ‘eja lokhom post ash mikadom’ (I would take her skin off her body). We have a night shift. 50 patients come with closed cervix. We have to wake up from sleep and go check patient.

The cervix is closed. I ask which baby is it? They say it is 6th or 7th. 'Khak da sar tu ke 7 o 8 ta zaeedi, tu dard awlad ta namifami,' (Go to hell you delivered 7 or 8 and still do not know your delivery pain). Her husband should beat her. She brings husband or in-laws or a few numbers of neighbours at midnight. They do not sleep and come with this woman with closed cervix. They should take her skin off her body."

While, I was looking at them in shock that the midwife could be rude and negative about her patients another midwife started blaming patients too:

MW (265): "When we send them back home they fight with us. They say, " You do not know anything. Why you don't believe us. Take off your white coats. Close the hospital door."

Another midwife (268) said: "We do not blame Primi because she is in-experienced. However if the 9th or 16th pregnancy comes with a closed cervix, I say I should put my hand in her vagina and take everything out Hahaha. I want to put my finger in and rupture the cervix so the baby is born easily. Hahaha. We are the unfortunate people with white coats. These low-status people talk badly about us."

This type of derogatory behaviour is common. It was strange to observe other HSPs reinforcing her words and justifying her behaviour. I sensed a deep hatred and indifference among the staff, which is illustrated in the discussion above. During the focus group discussions, HSPs compared patients' experiences and knowledge with their own, and as a result expected them to be calm and arrive to the hospital only when they were about to give childbirth.

It has been mentioned in the ANC policy that pregnant women and their family members should be counselled about preparedness for childbirth and what decisions need to be made in case of any childbirth complications before arrival at the health facility. However my research data does not indicate any examples of ANC counselling or discussion with pregnant woman and her family members related to childbirth preparedness. Policy implementation gaps are clearly increasing disrespects between patients and HSPs.

The data shows that in all health sections (ANC, PNC/ Family Planning and maternity) HSPs do not trust patients and mis-behave with them. It is clear that patients' trust and honouring of HSPs decrease when they experience harsh and indifferent treatment. When I asked why health providers insult patients during childbirth, some mentioned that patients are uneducated and do not know anything except childbirth, while others mentioned that

they misbehave with patients due to their family issues. A greater number of health providers mentioned that workload, night shifts and stressful work environment made them tired and they did not have the patience to behave kindly. A study by Rahmani and Brekke (2013) in Kabul and Ghazni provinces indicate that an additional factor underpinning substandard professional skills and disrespectful behaviour was that many HSPs were often unaware of reproductive health guidelines and professional standards.

8.5. Trust and Honour Between Health Service Providers (HSPs)

In ANC/ PNC/ FP or maternity wards, midwives usually provide health services but do not have the courage to ask seniors health staff questions, often out of fear of being judged or abused as inexperienced and unskilled. Data from interviewees also suggest that some of the reasons that midwives usually do not describe the procedure to the patient are also a lack of confidence in their own practice and/or lack of confidence in their colleagues' behaviour. If a junior health staff member makes a mistake, another member of staff will convey the information to seniors and that becomes a huge issue. She will be humiliated and discouraged. Gynaecologists in two district hospitals also described their lack of trust in midwives.

One of the gynaecologists mentioned that she checks each patient's medicine intake because she did not trust midwives. Doctors do not trust midwives and dis-respect them if they do not follow their instructions. For example, a doctor (373) during an interview mentioned that midwives do not seek to improve their knowledge and learn new practices.

“Midwives usually practice what they know and never seek advice from a senior. If midwives or nurses have some questions or concerns they are reluctant to ask their seniors.”

In addition, the corruption of some midwives causes mis-trust between HSPs and senior staff. The director of Dasht-e-Barchi district hospital (227) said during an interview that HSPs are not trustworthy.

“According to Dasht-e-Barchi community complaints some midwives were asking patients for a fee for service ‘Shirini’ Afs 2000-3000 (roughly £30) from each patients. If the patient could not afford to pay the fee, some HSPs were abusing and insulting patients. Midwives are very interested in having a night shift every second night. They want to be in pairs on

night shift so their turn comes every second night and they use the opportunity to ask patients for money. We asked the midwives to commit to not doing this, but still they do it. I warned them, but they still continue.”

In district hospitals (DHs) all health services are free of cost. However in Dashte Barchi DH some HSPs were happy to have night shifts duty in order to ask for fees for services despite also trying to sleep on duty. Those women who were not about to deliver a baby, and therefore who HSPs might not be able to charge fees for service, were not their favourite patients. Patients feel compelled to pay the fee of service. If they do not pay and they are poor and even face heavier risk of violence and humiliation. During my interviews, I found that many women saved some money or borrowed from some relatives or neighbours to pay the fee for childbirth services in maternity hospitals. In one of the district hospitals, I interviewed a pregnant Hazara woman (226) who wanted to have her health check-ups done. She was pregnant with her 7th child. She shared her previous childbirth experience.

“I will deliver my baby at home because I cannot afford it. When I delivered my baby last year, I had to pay Afs 1500 (roughly £15) as a tip because it was a baby boy. They were not happy with the money I paid and they swore at me. My husband is disabled I did not have money so I had to sell my home carpet to pay the childbirth fee in this hospital.”

The example demonstrates that due to illicit charges and poverty, women take the risk of home-based childbirth instead of paying money and being abused and humiliated by HSPs. The ‘under counter’ payments hinder patients’ access to SRH services. Those HSPs who work for NGOs earn a good salary. However other HSPs who only obtain a salary from the MoPH are not happy with their income and feel jealous of other health staff. In the admission section of a district hospital, during a focus group discussion (338-39,40), health staff talked about the factors behind financial misbehaviour with patients. Since they are MoPH employees they receive low wage and have no annual leave provisions. In addition, since they are not motivated to work hard and they feel so frustrated.

(338) *“You can see {name (340)}, She is an employee of (name) NGO. I hope she is not upset with me. I am service officer from MoPH and {name (339)}, is medical officer from MoPH. We receive Afs 4900 (roughly £50/ month) but she {name (340)}, earns Afs 14300 (£145/ month).”*

(340) *“The salary they pay is spent on transportation and food. So obviously it creates some conflicts.”*

(339) *“When we fight for our rights they say you feel jealous of others. When I am worried about my kids and economic conditions I cannot fully concentrate on my job and I am stressed.”*

Disparity of wage and rewards in particular hospital due to different employment contracts lead to a conflict among HSPs. Although many HSPs are friends, differences in salary scale and other opportunities have created a culture of jealousy in the health facility. Differences in work responsibilities also contribute to this. HSPs believe that there is a gap between their hard work and those who sit in front of computer and do nothing, which leads to resistance. A MoPH service officer (338) said:

“There was an officer and he came to take the heater from our office. He said, when I got the heater from your office I saw from your face how you react. I told him, you sit in front of computer all the day and might write 5 words but you are too exhausted to talk to me for a minute. We are humans. We visit 600 patients in a day. 600 times we ask for their names, 600 times we ask for their father’s names, 600 times we ask their age, 600 times we ask their home address. It has become 2400 words. Patients ask many other questions from us. We get tired and need some appreciation from our seniors.”

The lack of trust amongst health staff pervades the entire organisation. HSPs lack trust in service managers when they are ill. One said she informed the health officers that she was unable to come to work. Lacking trust in her they asked her to come and personally demand for sick leave to check her if she was actually ill and was telling the truth. A large number of health staff were unaware of their labour rights and benefits. In particular those HSPs who started working with NGOs mentioned that they had not receive a copy of their work contract. One of the health staff (302) asserted that the level of mistrust and disrespectful behaviour at the senior level had a negative impact on her attitude.

“ At the work place unfortunately no one respects each other. Everyone judges and abuses. It is not only the experience of abusive behaviour that makes you depressed but also the numerous incidents of violence and spats. Many HSPs have family issues. They are also under pressure with heavy workload and a disrespectful work environment. We as HSPs are never appreciated in workspace. Such conditions increase the level of distrustfulness and frustration. So nobody will be offered better services. I encourage everyone to share their problems with the seniors but because they fear losing their jobs they never say anything.”

This quote suggests that a small gesture of appreciation could bring about a great change in HSPs behaviour and their work outcomes. It is possible that if HSPs work is appreciated they might be encouraged to deal more kindly with patients.

In summary, a lack of trust and honour were observed among health professionals at all levels. Senior employees behaved in a harsh and abusive way towards other staff, doctors misbehaved with midwives, and midwives and doctors misbehaved with patients and hardly trusted each other. Observations and interviews reveal that there are many factors that impact on HSPs behaviour. The predominant factors were insecurity, low wages and a lack of trust and honour at the health facility level. It is discussed that there are many organisational human resource and or management levels failures at play in health facilities. For instance, missing contracts, lack of care for staffs' well-being and mental health, refusal or inability to discipline malpractice and corruption, lack of effective training and appropriate educational resources are among the main factors that impact on HSPs ability or desire to treat patients well. It therefore follows that the higher quality of SRH services will be improved if HSPs work in a supportive and trustable work environment. A summary of gaps at the health service provision level is demonstrated in figure (12), which is followed by summary of recommended interventions for short, medium and long-term actions at the health service provision level in Table 14.

Figure 12. Summary of Identified Areas of Deficiencies at the Health Service Provision Level



Table 14. Summary of Recommendations at the Health Service Provision Level

Health Provision Level	Interventions	Short-term Actions	Medium-term Actions	Long-term Actions
	Mobile Clinic Activities	<ul style="list-style-type: none"> - Increase access to SRH services - Increase SRH awareness through male and female health educators - Reduce overcrowding in HF's - Increase in SRH service uptake 		
	M&E		<ul style="list-style-type: none"> - Routine practices - Post capacity building trainings to observe the translation of knowledge into practice - Increase quality of health service provision 	
	Absorption of Resources from private institutions		<ul style="list-style-type: none"> - Increase in number of health educators - Financial support 	<ul style="list-style-type: none"> - Job creation at the community level - Task shifting to CHWs
	Professional Communication		-Plan and design training programmes to improve HSPs professional communication skills - Provided technical and linguistic training to HSPs	<ul style="list-style-type: none"> - Reduce language barriers and misunderstandings between HSPs and patients through professional communication training in two local languages - Create trustable environment
	Professional Ethics Enforcement		<ul style="list-style-type: none"> - Increase proper routine SRH practices - Emphasis on considering patients' rights, privacy and values 	<ul style="list-style-type: none"> - Reduction of judgmental and abusive behaviour amongst HSPs - Increase trust and honour between HSPs and patients
	Switching from a Bureaucratic Health Service Provision to Digitalized System		<ul style="list-style-type: none"> - Proper reporting process to HMIS - More time for patients - Increase proper surveillance system - Robust organisational work and health service provision planning 	<ul style="list-style-type: none"> - Digitalising health facilities' reporting system - Reduce multiple forms and integrate patient's record in one file - Improve communication and knowledge transfer - Improve HSPs' face-to-face communication with patients
	Psychosocial Support		<ul style="list-style-type: none"> - Increase psychosocial counselling at all HF levels - Improve patient's referral system 	<ul style="list-style-type: none"> - Support for GBV survivors and women's mental illnesses - Provide psychosocial support to HSPs
	Male Involvement		<ul style="list-style-type: none"> - Recruitment of male HSPs - Training of male HSPs for ANC, FP and mental illness counselling - Task shifting among HSPs 	<ul style="list-style-type: none"> - Encourage men to accompany their wives and take part in ANC and FP counselling and decision making - Reduce sensitivities - Increase SRH service uptake
	Knowledge Transfer and Exchange (KTE) & IEC/ BCC		<ul style="list-style-type: none"> - Effective in-service trainings - Increase SRH awareness - Capacity building - Exchange the incentive trend to compulsory professional training 	<ul style="list-style-type: none"> - SRH knowledge improvement - Changing socio-cultural beliefs and detrimental practices - Knowledge exchange decreases sensitivities about SRH issues and stigma - Improve positive attitude of HSPs towards patients

Chapter Nine

9. Sexual Reproductive Health System Level

9.1. Communicating SRH Issues at the Health system Level

Afghanistan is one of many low-income countries that has adopted the WHO's SRH Policy. The 'sexual reproductive health' title, along with its SRH components, is commonly implemented in many countries. However it is not the case in Afghanistan. The Afghan health system overlooked the word 'sexual' from the WHO Policy because words such as; sex, sexual or sexuality are very sensitive in Afghan society. During the adoption of the WHO SRH Policy, the MoPH senior staff in the reproductive health department decided to avoid the use of 'sexual' in Policy, and Strategy documents and Protocols and indeed in the department's own name.

Although, the MoPH/RHD had an updated version of the Policy, Strategy and Protocol, issues related to sexual health were not incorporated into reproductive health strategies and have not been enforced at the health system and the health service provision levels. This condition portrays policy-makers' ambivalence about communicating SRH in the Afghan health system.

However it is evident that the MoPH could play a significant role in ensuring that health care is equally provided based on policy standards. MoPH senior staff pointed out that many challenges and gaps in the Afghan RH Policy and Strategy have emerged due to limited communication at health system level. The head of the Reproductive Health Directorate (RHD) (317) addressed a lack of interdepartmental communication.

"I am not in a position to know what the relevant departments do? Seniors should communicate and point out the gaps and problems in their projects. Each health project is based on political interests. What solutions do they suggest? Again next year the same report or survey data will come. One department gets a plan and continues working on it without informing other departments. No one talks and complains that last year there were the identical issues and what reforms have you made? Why isn't there any improvement? There is a problem at the policy coordination level. Why are

the results of interventions, decisions and evaluations based on evidence not applied? ”

In Chapter 5, I discussed the donors’ power dynamics in terms of contracting out health projects and their role in implementing RH Policy. This quote from the RHD head shed light on issues of power and political interests between the Ministry of Public Health (MoPH), donors and implementing organisations, and provides evidence that the RHD is not in a position to fill the communication and coordination gaps. In a focus group discussion with health system level participants, a safe motherhood officer (331) confirmed the existence of communication and mis-coordination gaps at the health system level.

“Communication and coordination is very poor. Look! Every department has a task force meeting. Each department identifies the gaps. It means that somehow we have a system but no communication and coordination around reproductive health system gaps.”

The collected data indicated that there were disparities in SRH policy implementation among HSPs, implementing organisations, donors and MoPH/RHD due to limited communication. For instance, a national Non-Governmental Organisation (AFGA) provides free contraceptives and child spacing counselling while the marketing officers of another NGO (MSI) sell the contraceptive products door to door. The disparity between the implementing organisations’ work practices might have a negative effect on the uptake of contraceptives. After sharing these disparate practices the head of RHD (317) expressed her unawareness of this issue.

“I am not aware of this. No one informed me. I think this organisation should distribute IUD or pills to health providers instead of selling them to patients.”

The RHD asked the officer of the family planning department about this issue and she (328) was also unaware of such differences in practices between implementing organisations.

“MSI has its own policy and we cannot change it. The only thing we can do, is to monitor them. We will tell them that IUD and implant capsules should not be distributed. Only three methods should be distributed (oral pills, injection and condoms).”

The conversation shows that in addition to inter-ministerial and interdepartmental communication breakdown, there is limited communication and monitoring around the activities of implementing organizations. MoPH/RHD departments conduct monthly meetings with donors and implementing organisations. However my observation notes indicate that such issues have not been discussed and there were no suggestions for improvement.

In RHP&S implementation gaps exist from other sources as well. A few sentences within the RHP&S highlight the importance of male involvement in SRH. However, policy-makers and implementing organisations try to avoid male participation especially when communicating about SRH. One of a donating organisation's officers (336) during a focus group discussion explained that:

“We included male participation in RH Policy, but it is not implemented. In RH Policy and Strategy we talk about birth spacing but we never discussed population control. This is a gap. Even the highest-ranking staff did not understand it. Correct! There were a family planning workshop and the public health officers, especially men, did not listen. Some of them were laughing and making jokes. Even the Public Health Provincial Officer himself is not willing to comply with the family planning program implementation in his province. If there is no commitment at the upper and middle levels then how do you expect it from people? Public Health officers or Reproductive Health officers have many children so how can we expect them to communicate contraception with local people and encourage men's involvement in the reproductive health sector?”

As was discussed in Chapter 8, health service providers and senior health staff are also members of Afghan society and prevailing sociocultural beliefs influence their perceptions and behaviour. A consultant for mothers and childcare in one of the USAID projects (326) that provide capacity building training to health staff, underlined the lack of men's involvement in the reproductive health sector and lack of knowledge around reproductive health particularly, family planning methods, application, benefits and side effects.

“We usually have male involvement in the training but whatever they learn they never transfer the knowledge to other HSPs and patients. In my opinion, all male and female HSPs should be aware of SRH issues and should coordinate the implementation of

protocols. I remember, one of the male health experts on TV was saying “Oh women, you obtain contraceptives but these medicines will kill you eventually”. He is famous and he is a specialist. When he talks like this on TV, obviously many people believe the incorrect information.”

The Health Coordinator for the Aga Khan Foundation (AKF) (335) during a focus group discussion shared some significant recommendations for tackling the lack of implementation of improvements to reproductive health systems.

“Even if we have strong policies, if the level of awareness is not increased, we cannot achieve our objectives. I have seen many religious leaders signing the Family Planning memorandum but there was no follow up. I was part of this experience. The memorandum is only hung on the wall so how should religious leaders get involved practically? Should some informative material be published for Imams to use in sermons? They are the principal source for communicating health issues with people so they strengthen our strategic objectives at the RH level. There is a need for education about reproductive health. We need a holistic approach to bring about a change in society.”

Information from senior health staff demonstrated that they understand the challenges within complex health systems but deal with them by blaming others. They did not offer any specific solutions for reducing communication gaps at the health system level.

One of UNFPA Subnational Officers (333) who worked in 5 provinces of Afghanistan shared his experience of communication and conveying reproductive health awareness to community members in a district in Khost province.

“The program manager of an NGO in Khost province told me that in one district people are conservative and closed our clinic. I asked why it was closed? He said, “People think that we try to reduce the population of Muslims.” When I went to the site people said, “If the number of children we have is decreased, so gradually the population of Muslims will be reduced. We do not want our women to lose fertility.” I asked them what this clinic was for? They answered, “This is for those people who are ill and come here to obtain a few tablets.” Our implementers did not know about the basic components of health education. In the presence of senior health staff of that NGO, I explained that this is birth spacing clinic and we should care about women’s

reproductive health. People said, “We paid 7-8 lacks (roughly £8000) as bride price for each woman. It is difficult to marry because there are no jobs. No one in our community told us that a clinic has such benefits. We thought that a clinic is a place to take some tablets if you feel ill.” Afterwards the level of utilization of maternal health care services increased dramatically because we invited many people in the district, and even the head of the tribes participated.”

This quote suggested that proper knowledge transfer and communication with people, especially men who are not well aware of SRH could increase the level of health care services uptake. It indicates that the MoPH need to involve more men in SRH knowledge transfer. A good starting point for senior staff and policy makers in increasing communal SRH knowledge would be boost the understanding of staff working within the health system and especially by encouraging greater involvement of men who have formal responsibilities for SRH.

9.2. Trust and Honour at the Health System Level

It was discussed that there is a lack of communication and knowledge at the interdepartmental and inter-ministerial level and between donors and implementing organisations. Such conditions create an environment in which each senior staff at the health system level critique each other’s work. Similar to the health service providers, staff of MoPH/ RHD complained about dis-respectful and discriminative behaviour amongst departments’ staff. For instance, family planning officers (328,329) discussed the negative impact of such behaviour.

“Even our attitudes are changed. When we go home we speak rudely with family members because we are under work pressure, and we also face the same harsh behaviour of colleagues. There are many who act as if they are superior in order to humiliate and insult others.”

At the health senior level verbal and behavioural violence is considered to be normal. It is quite strange that the reproductive health director (317) herself admitted that at all levels people behave harshly and humiliate others. She illustrated this with an anecdote.

“It is okay if health providers use abusive words or misbehave. They beat the patient. Once I heard from RH officers that a woman came for childbirth. The HSP said, “You will not

deliver now just go back home.” She had convulsion due to E-clampsia. Everyone from the health staff was beating her and saying do not deceive us, go home.” Consequently, the woman gave birth to her child and died of convulsion.”

Although some senior health staff (325,331) linked such misbehaviour to low level of salaries, high workloads, frustration and mistrust they did not recommend any solutions. The senior reproductive health staff also acknowledged that a large proportion of senior health staff accepted that HSPs do not abide by the medical ethics. Sometimes HSPs even throw papers at patients or other health staff face and sometimes they hit the patient. The focus group discussion heated up when one of senior health staff (321) validated this misbehaviour and mistrust.

“Health staff, especially doctors, should not be blamed. Did anyone ask a doctor about her salary? Listen! A doctor in a maternity section has a night shift duty every three nights and 24 hours she is standing by the patient’s bed. Every night she helps 150 women with childbirth and conducts 20 cesarean operations. In the morning patients come to her and express true and false health issues. Do you expect her to behave well with patients? We cannot prosecute a doctor. Workload and low salary has a direct impact on the behaviour or mental health of a doctor. No blame, no name, no shame!/? Listen! There is a problem with the system. The problem is not with the person.”

This was very perceptive comment, although it goes to the extreme of not blaming individuals at all. Many of the problems that manifest in HSP stress, poor maternal health and poor behaviour are system induced. I observed that the FGD participants themselves could not tolerate criticism and became very defensive, accusing each other and demonstrating the same behaviours as discussed on HSP level in the previous chapter.

At the end of this FGD, one of the mental health department officers (320) discussed further issues related to the lack of trust and honour in the health sector,

“We live in Afghan society. No one can tolerate others criticism. You cannot conduct a dialogue for more than 10 minutes. You start fighting, the volume of your voice rises and your faces get red.”

I observed some participants were smiling... He (320) continued...

“We know a doctor for example, has a load of patients. Her income is low. She has problems in the household. The social conditions are bad. On her journey from home to hospital 5-6 vulgar people bother her and when she goes back home. There are many security issues. These all have a negative impact on their behaviour. Many of us, in fact over 80% of us, suffer from mental illness, so how could we expect mutual honour and trust?”

It is evident that the MoPH is situationally placed to play a significant role in ensuring HSPs health and well-being. However, the factors behind trusts and honour gaps within the HSP level also play out at the MoPH and implementing organisations levels. The mental health officer’s statement highlights that Afghans, as a society has to deal with protracted war and social issues. Every member of the society is affected, regardless of his or her social position and educational background.

On reflection, it should not have been surprising that the research data shows the chain of trust and honour absence also manifests itself amongst health system level staff and the coordinating organisations. The senior staff blamed each other for not being honest in running health projects and reporting their activities properly. In addition, system level health staff identified major gaps within RH provision and the wider health system that directly and indirectly impacts on the level of communication and trust, but no one had specific solutions for these major problems they shared. A summary of gaps at the Health System Level in Figure (13) is followed by recommended interventions Table (15) at the health system level.

Figure 13. Summary of the Identified Areas of Deficiencies in the Health System Level



Table 15. Summary of Recommendations at the Health System Level

	Interventions	Short-term Actions	Medium-term Actions	Long-term Actions
Health System Level	Review similar contexts' effective SRH interventions		<ul style="list-style-type: none"> - Inclusion of SRH in Political Agenda Replicate applicable global interventions according to the Afghan culture - Ownership of their own ideas 	
	'Framework of action' Monitoring and Evaluation (M&E) and SRH service quality assurance		<ul style="list-style-type: none"> - M&E health service practices against national health needs - Support various actors contribution - Exploring health system barriers - Identification of disparity of similar SRH projects' activities - Routine SRH practices quality assurance - Effective SRHP implementation - Improves multi-sectorial communication and coordination - Identification of implementing organisations' weakness or strength and performance outcome 	
	Enhancing Surveillance System		<ul style="list-style-type: none"> - Reporting process to HMIS - Health database management - Digitalization of health facilities' reporting systems and database management - Promote Political commitment - Help the MoPH/RHD to evaluate the health facilities' routine practices and identify the burden of SRH issues and women's health needs 	
	Professional Ethics enforcement Discipline Malpractice and Corruptions		<ul style="list-style-type: none"> - Design capacity building training programmes to enhance HSPs knowledge and accountability for medical professional behaviour, patients' rights and privacy and professional commitments - Increase quality routine SRH practices - Promotion/ demotion - Transparency in employees' contract details - Reduce paperwork to increase HSPs contact with patients 	
	Civil registration system and Electronic National Identity		<ul style="list-style-type: none"> - Home based or institutional childbirth registration - This action would help the Central Statistics Office (CSO) to obtain factual statistics instead of estimating birth and death ratios. If the MoPH in collaboration of Ministry of Justice (MoJ), Ministry of Hajj and Religious Affairs (MoHRA) and Ministry of Communication & Information Technology (MCIT) enforced the distribution of electronic national identity and registration of marriage 	<ul style="list-style-type: none"> - Improve records of births and deaths, marriages - Decrease the level of young age marriage, home-based childbirth and high-fertility rate. - Improve measurements of life expectancy and delay young age marriage.
	Sustainability of SRH Projects and International Funds		<ul style="list-style-type: none"> - The MoPH in collaboration with international donors could also plan for capacity building with national HSPs 	<ul style="list-style-type: none"> - Sustained political commitment, inclusion of all SRH needs in the political agenda - Proper financial and management planning - Multi-sectoral commitment would improve a broad and

				equal access to SRH services
	Behavioural Change and Communication/ Information Education and Communication IEC/ BCC and use of Mass Media		<ul style="list-style-type: none"> - Design socially acceptable SRH advocacy programmes - Provide SRH messages through use billboards - Produce and distribute a variety of SRH advocacy materials (picture messages/ posters) to educate a largely non-or semi-literate population to promote SRH service uptake 	<ul style="list-style-type: none"> - Increase SRH awareness - Promote multi-sectorial coordination and communication - Change socio-cultural beliefs and detrimental practices - - Produce radio and video spots and dramas in both Dari and Pashto languages to educate people on healthy practices and promote Health seeking behaviour change. - Decrease sensitivities about SRH issues and boosts confidence to properly communication SRH issues
	Psychosocial Support		<ul style="list-style-type: none"> - Recruitment of resources to support GBV cases - Increase psychosocial counselling at all HFs - Support for GBV survivors and women's mental illness 	<ul style="list-style-type: none"> - Elimination of Interpersonal violence - Support the integration of mental health and psychosocial counselling services into the public health system of Afghanistan
	Comprehensive Sexuality Education & Mobile health (m health)		<ul style="list-style-type: none"> - Improve multi-sectorial coordination - Use of Mobile phones to increase people's awareness - Encourage private sector's contribution - Technology-based sexual and reproductive health interventions via smart phones 	<ul style="list-style-type: none"> - MoPH/ RHD can design effective and socially acceptable Sexuality Education programmes with collaboration of Ministry of Communication & Information Technology (MCIT) and MoE - Improve SRH seeking behaviour
	Knowledge exchange & Transfer Telemedicine technology system for insecure and unstable locations			<ul style="list-style-type: none"> - Develop cost-effective capacity building programmes - Interdepartmental SRH awareness - Increase the level of social awareness through various channels - Reduce concerns over reduction of external aids - Increase SRH awareness. Commitments to connect national health facilities to the main hospitals and international health institutions; in order to improve quality health services
	Sexuality education to those adolescents who have access to schools			<ul style="list-style-type: none"> - Plan and design effective sexuality education school programmes with collaboration of MoE and MoHE and some implementing - Change socio-cultural beliefs and detrimental practices - Inclusion of reproductive health curriculum in the schools subjects

Chapter Ten

10. Discussion and Recommendations

10.1. Discussion

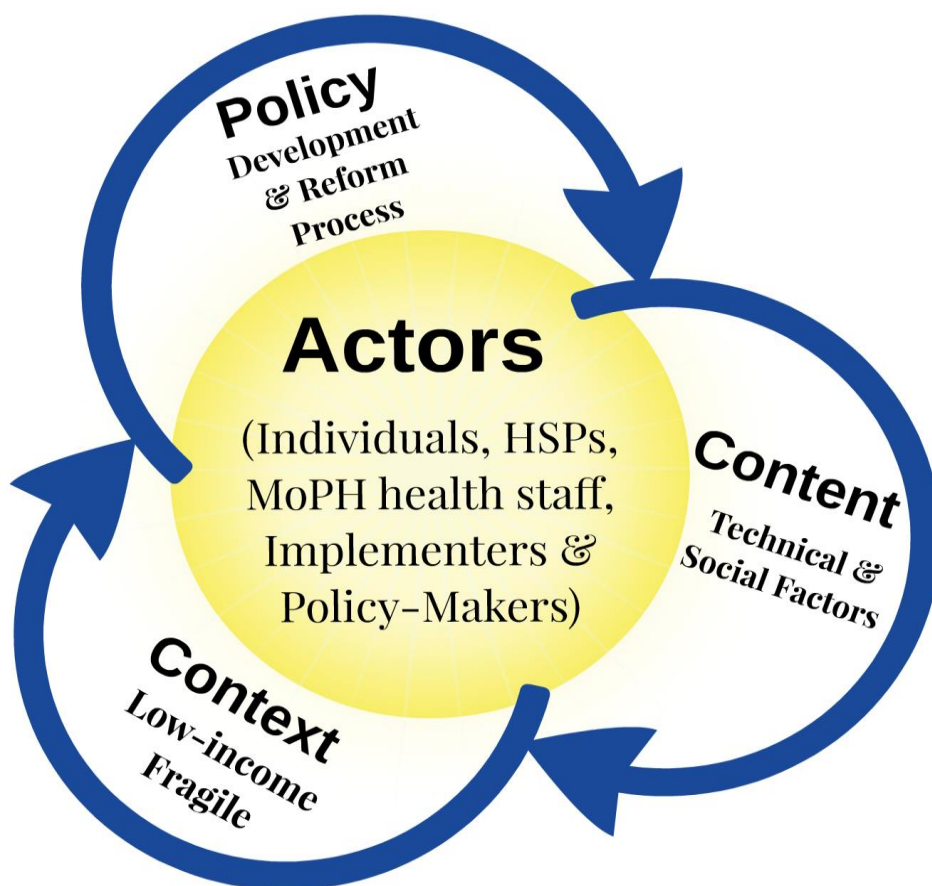
The policy and social issues relating to the uptake of SRH services were identified in the previous chapters. The application of Walt and Gilson's 'Broader Framework of Thinking' (1994) has helped analysis of my policy content and the identification of actors' roles and power relationships in terms of the failure or success of policy process and implementation.

My research develops this model in the analysis of SRH in the context of fragile states. Although the 'The Broader Framework of Thinking' model is static discreet in research it can be argued that this model is dynamic and illuminate the information, which led to address the issues and include people from diverse social background and policies to device the change. For instance, regardless of more emphases on the technical content (policy) in the 'The Broader Framework of Thinking' model, social factors that directly and indirectly impact on SRH policy development, reform and implementation were additionally explored.

Furthermore, I needed to find actors who had more power to stand or make changes that women as individuals cannot. In fact, donors and international implementers' power dynamics play out in the reform and effective implementation of SRH policy. Therefore, I modified 'The Broader Framework of Thinking' model.

Figure 14 demonstrates the dynamic interlinks between elements of the 'The Broader Framework of Thinking'. This modified model demonstrates that in a fragile and war-affected context like Afghanistan, reform and effective implementation of a culturally acceptable SRH policy is associated with diverse actors' roles and power and a deep understanding of social factors.

Figure 14. Modified Version of 'The Broader Framework of Thinking' Model



There are numerous interlinked issues at the individual, health service provision and health system levels that impact on SRH service uptake. In essence improving SRH uptake is not only about improving the design and implementation of health policy. The wider social context should be considered and fed back into the policy and professional practice, which shapes the complex SRH system.

Afghanistan is an ethnically diverse society, which suffers from political instability, poverty, joblessness and inadequate education. As this and the period of war have left Afghans in a really bad situation. It is revealed that in the Afghan context, there is a relatively weak state, which is dependent for health investment on foreign government and organisations. This condition results in poor commitment to Social Determinants of Health (SDH) policies to address SRH service uptake improvement. Evidence from policy analysis show that decision-makers often rely on statistical data but lack understanding of the broader context and the causation path, which is vital to the evolution of effective solutions.

In various contexts, particularly conflict-affected and poor-resourced countries like Afghanistan, health systems usually adopt and adapt the policies and guidelines of other countries, and fail to identify the actual health issues and needs in their own setting and/or the specific mechanisms that underlie their successful adoption within their own context.

There can be no one solution, or even a series of technical solutions, to such complex problems. I believe that understanding the success and failure of SRH system interventions from other countries would enable me to think critically and systematically, and recommend some applicable integrated interventions. Hence, my discussion of my results is interwoven with lessons from elsewhere.

10.1.1. Sexual and Reproductive at the Health System Level

My policy analysis shows how culture affects MoPH officials' and health professionals' views of what they can and should do e.g. the first issue in the Afghan RH system is the omission of 'Sexual Health' from the policy. Since MoPH officials and health professionals at the policy making level are reluctant to communicate around sexual health, the Reproductive Health Policy and Strategy only addressed reproductive health needs.

Moreover, some components within the reformed RHP&S (2012-16) have not been implemented fully, due to the lack of coordination, knowledge and communication. For instance, there are no focal points from NGOs to follow-up and report activity outcomes to the MoPH/RHD directly. Moreover, due to the lack of trust many survey results, interventions and monitoring reports were not disseminated and incorporated into the reform process of the National Reproductive Health Policy (NRHP).

Issues around curable and preventable diseases such as STIs, pregnancy and childbirth complications were highlighted in the NRHP. The high prevalence of STIs among women is due to the lack of knowledge of hygiene and lack of communication about intimate parts. For instance, a study of Knowledge, Attitude and Practice (KAP) with 468 women of reproductive age in four hospitals in Kabul, showed that only 24% of the women had knowledge of STIs and the majority of women did not know how to prevent infections of intimate part (Egmond 2004). It has been highlighted in a number of studies (Gottlieb 2013, WHO 2013d, Aggleton 2014) that addressing these health issues in RH policy, and enforcing into practices mainly through STI treatment management and health promotion programs might have two impacts. First, the level of awareness of STIs prevention will increase amongst women. Second, there will be a tremendous reduction in the number of STIs incidences, which will result in less overcrowding at the health facilities. Such outcomes will be largely dependent on STI prevention and male willingness to be involved.

In all six components of NRHP, there has been an emphasis on Information, Education and Communication/Behavioural Change Communication (IEC/ BCC) and a major focus on capacity building training. Every year thousands of capacity building training sessions are conducted for the HSPs but there has been limited positive behaviour change. It would be valuable for the training organizers to

observe how training and knowledge is translated into practice. In addition, training programs cannot only be restricted to the HSPs. Trainings could be planned to cover all three levels (SRH employees, HSPs and patients).

Male participation is addressed in the RH policy indistinctly. In other words, both socially and within RH Policy and health service provision, Afghan men are excluded from any consideration of the SRH of women. For instance, a number of religious leaders signed a memorandum of understanding with the RH directorate in support of the Family Planning awareness programme but did not support family planning. The research data also indicates that religious leaders do not support girls' education and marriage only after they have finished school. To achieve the aim of male involvement in the reproductive health sector, there is a need for an attentive review of policy and multi-sectoral collaboration.

The RHD and policy-makers could also include a focus on male sexual health because men also confront sexual health issues (e.g. erectile dysfunction, premature ejaculation, RTIs and STIs etc.), which appear to have been overlooked. It is evident that male health providers cannot usually provide SRH services to female patients considering the sensitivity of Afghan society. However increasing the number of skilled male HSPs in the field of men's sexual health issues, psychosocial and family planning counselling, and helping make it more acceptable for men to discuss these, could have a significant impact on men's awareness, their own SRH and women's SRH and well-being.

The Greene (2006) 'male involvement model' and the IPPF (2010) case studies from various countries (e.g. Namibia, India, Bangladesh, Canada etc.) highlight the role of male involvement as a partner, utiliser and activist for change. These male roles improve the reduction of gender inequality in terms of SRH service utilisation, equal decision-making amongst partners, SRH advocacy and changes to some in appropriate sociocultural beliefs. This model was applied in the Ugandan context (Stern 2015), where male HSPs were recruited to provide SRH services to male clients, whilst male volunteers educated people at the community level, resulting in more mutual decision-making and empowering women to devote time to income generation and financially support their husbands' unemployment.

The implementation of such initiatives might be erratic in diverse settings due to differing rates of cultural acceptability and men's pre-existing knowledge (Ivanova

2015, Ghosn 2012). If carefully tailored to the Afghan contexts, such programs might reduce young age marriage, violence and discrimination against women and promote girls education, parents' effective communication with children and safe pregnancy and childbirth (Ivanova 2015, Mullany 2007, Shahjahan 2013, Ampt 2015, Ali & Ushijima 2004, Stern 2015).

It is essential to note that associated health issues, such as addiction in women, is missing from the policy. According to the RH director, projects are not supported by powerful players and not funded due to rested political interests, which impacts on the development of guidelines and protocols at the health facility and community levels, particularly around efforts to improve mental health screening, psychosocial support and the treatment of addiction.

The policy analysis showed policy content and policy implementation gaps often flow from challenges in terms of actors' roles and power dynamics and the influence of political and economic dimensions on policy reform and implementation processes. In other words, power is multi-layered and a fundamental aspect in terms of policy-making process and implementation. However little explicit attention has been given to power related factors in health service provision and utilisation levels in Afghanistan (Buse 2008, Erasmus & Gilson 2008).

Data from HSPs interviews and FGDs, including the Ministry and coordinating organisations' staff and decision makers demonstrated that major social impediments to SRH service uptake, including a lack of communication and knowledge exchange about SRH projects and activities, pervade all levels of the health system. Gaps at the inter-departmental, inter-ministerial and inter-sectoral, coordination levels, together with MoPH/RHD unawareness of many entities' ongoing efforts or work outcomes hinder implementation and coordination across government entities and intermediate and individuals levels.

It is important to note that the role of the MoPH/RHD is to ensure that SRH services are based on standards. The RHD emphasizes the responsibility of implementing organisations to enforce SRH policy but the process to improve coordination and a proper system to evaluate immediate health service outcome is radically inoperative. For instance, the department of midwifery has no information about midwives' routine activities in various health facilities. Likewise, various RHD departments are not aware of each other's activities and work outcomes. Those MoPH

departments, which are funded by international organisations (such as the Family Planning department, which receives funding from MSI) are more likely to report back to their funders than the MoPH because they receive salaries and other funds from these organisations.

There is need for a fundamental change in the Afghan bureaucratic reproductive health system because much paperwork hinders health service providers' face-to-face communication with patients and trust building. Such conditions impede proper routine health practices as well. Therefore, high-impact reform could bring about a constructive change in women's health condition if policy, strategy and processes are significantly improved (Waldman & Newbrander 2014).

Foreign funding is part of the power dynamics that contribute to closing SRH service provision gaps. There is simultaneous lack of coordination between the international organisations and the MoPH/RHD. The MoPH often has no control over health projects and is not aware of implementing organisations' activities. Improving coordination, communication and knowledge exchange with donors, coordinating and implementing organisations will ensure the formation of effective networks (Best 2010) and significant implementation of health programs and SRH information management. More importantly, MOPH/RHD will be able to improve women's health and well-being.

In chapters 4 and 9, we discussed that from the publication of RHP&S to health service provision and health promotion programs, RHD predominantly relies on international funds. In fact, international bodies play a substantial role in shaping or implementing policy. For instance, RH Policy and Strategy were published with the financial support of USAID. In terms of young age marriage and SRH related complications, some private TV channels broadcast awareness video spots and messages. However these messages can only be broadcasted if they are paid for an international organisation such as UNPFA. Thus, the sustainability of health programs depends on donors funding.

While implementing organisations claim to be responsible for the effective implementation, monitoring and evaluation of health services (Waldman & Newbrander 2014) diverse implementing organisations run similar projects with different plans and objectives. For instance, Marie Stopes International (MSI) and Médecins Sans Frontières (MSF) both provide contraceptives. However MSI marketing officers sell contraceptive products door to door while MSF distributes

contraceptives free of cost. During an interview, the department of family planning expressed their unawareness of this disparity, which itself displays a lack of coordination and communication.

On the one hand, it is positive that MSF provides SRH services including free emergency obstetric care, to most women. On the other hand, that is still a concern because health services to poor people are still highly dependant on international funds. MSF targets localities where care is most needed but in doing so they may inadvertently create other problems. For instance, those women who had a caesarean section (C/S) will be the candidates for C/S in future pregnancies as well. As there is no guarantee that MSF will remain in Afghanistan long-term, any closure of their hospitals due to the lack of funding and security might put the health of mothers in danger.

The main themes of the NRHP&S are quite sensible because they focus on common health needs but because the needs are so overwhelming that would create other needs when women cannot access health facilities and end up having to deal with emergencies themselves. This is largely because the health system is under-resourced and under funded. For instance, MSF mobile teamwork was restricted due to insecurity and lack of funding. MSF stopped providing ANC/ PNC and FP services in the 'Spina Poza and Pul-e-Charkhi' sites and instead promoted vaccinations for children.

In addition, adoption of global policy and guideline components is sometimes not aligned to public needs and the level of acceptability. For instance, we discussed how WHO' FP decision-making tool (2005) was adapted by an MSF funded district hospital. However the HSPs during counselling were reluctant to use the tool as a result of the cultural sensitivity. Thus, a proper evaluation of programs and feedback would improve information flows and collaborative activities between various, implementing organisations and HSPs.

The MoPH/ RHD staff stated that a significant problem impeding the introduction of social programs is insufficient support from the MoPH in terms of policy around family planning. For instance, the family planning department only had two employees, and both received their salary from MSI organisation. They required 4 more staff but due to the lack of funds failed to fill the vacancies.

Similar problems exist with respect to mental health care. It is discussed in Chapter 5 that maternal mental health and psychosocial support services are elements of the sixth component of RH Strategy. However funding for this comes from the German Foreign Office and the European Union and the Mental Health Department (MHD) is supported. Psychosocial support to patients is provided through one International NGO (IPSO) and in 2014 this organisation downsized its staff and restricted their services in the district hospitals due to limited funds.

Monitoring and evaluation (M&E) has a strong effect on successful SRH. An effective M&E process to measure the outcome of health improvement programs such as training is imperative, but missing in the Afghan health sector. For instance, assessment of implementing organisations' routine practices and health programme outcomes would ensure proper implementation of NRHP&S. In addition, with the technical support of international organisations, many training courses are organised for HSPs but the ways knowledge is put into practice on the ground is not monitored and evaluated.

A large proportion of HSPs followed training for Gender Based Violence (GBV) however in many good intentions they recorded, my observation of their practices suggested that HSPs have not absorbed the issues and forgot what GBV means. Since HSPs in DHs and CHCs do not practice psychosocial support as part of their routine practices, GBV cases are not recorded. Where HSPs are aware of GBV they commonly do not refer violence survivors to psychosocial counsellors because they believe that the GBV concept is adapted from Western countries and relevant services are not applicable in the Afghan context. This is particularly because violence is commonly practiced and GBV in particular is an accepted norm in the Afghan society.

Health systems can play a significant role in terms of effective responses to interpersonal violence against women. To address interpersonal violence as part of SRH priority, some countries adapted WHO (2013a) GBV against women guidelines (WHO 2013b) and developed action plans and protocols to address violence against women. However, adoption of such programs in Afghanistan might be a long term process because there is a lack of inter-sectoral coordination for sustainable programs, lack of qualified health staff, extended socio-cultural norms, normative religious beliefs and associated behavioural barriers (Vieira 2009, Usta & Farver 2007, UN-ESCWA 2013, Usta 2012, 2014).

It is important to note that few marriages are registered in Afghanistan because marriage registration is a taboo in the Afghan society and regulation for registrations is rarely enforced. In addition, most deaths and 65% of home-based childbirths are not registered. Obtaining statistics from effective civil registration is imperative for Afghanistan because a valid and reliable source of data would provide the statistical information about maternal mortality and morbidity ratios, total fertility rates and life expectancy in the Afghan context (Byass 2011, Yamin & Boulanger 2013) that is vital for effective planning.

This research shows that MoPH health staff understands the complexity of health systems and admit them. However they did not offer any specific solutions for reducing communication gaps at the health system level, building trust and honour and collaborative environments within the RHD, let alone more widely the health system. To strengthen SRH, there is need to include health issues more explicitly within the political agenda and seek multi-sectoral commitment and technical and monetary support. In addition, having politically powerful leadership enhanced planning and improved management of bureaucracy could help obtain adequate health resources, foster the capacity and skills for higher quality health service provision and provide proper surveillance and reporting systems (Scheel 2011). Achieving improved SRH service uptake through such multi-sectoral, political and technical collaboration will take a long time, but the outcomes could be remarkable.

10.1.2. At the Health Service Provision Level:

Chapter 8 demonstrated persistent SRH knowledge and communication gaps in HSPs routine practices and an absence of trust and honour among HSPs. Senior employees behave harshly and abusively with other staff, doctors misbehave with midwives, and midwives and doctors misbehave with patients and hardly trust each other. In addition, the bureaucratic system also widens the distance between HSPs and patients. This research highlighted that one of the major issues was the failure of organisational management.

The officers and heads of the four health facilities usually lay blame or responsibility at the feet of the front-line workers. However the Human Resource (HR) and management rarely acknowledge that front-line failures and inadequacies reflect management shortcomings, nor do they discuss the extent to which they can be responsible for HSPs anti-social behaviour, which might not be so prevalent if management were more supportive or organised themselves better and showed respect for the staff.

Poor hierarchal organisational management exacerbates the power of resistance towards an effective implementation of SRH policy (Erasmus and Gilson 2008). Various actors play a substantial role in terms of policy reform and implementation but sometime use their power against it. For instance, HSPs exercise resistance through their actions and use of language to control patients, and make them do what they presumably want. Such power is also exercised in their routine practices. For instance, HSPs in ASB/ DH had did not follow routine practices in ANC / PNC and FP sections (blood pressure check, weight measurement, distribution of necessary medicine). In other DH the official working time was from 8-4 but HSPs would refuse to obey this rule and leave the hospital at 11:30 a.m. or 12:00 p.m. Moreover, their resistance to the health policy implementation process was also observed when awareness-raising materials were left in the cupboard e.g. the Family Planning decision-making tool was overlooked by HSPs due to their reluctance to use what they thought was culturally inappropriate material.

Chapter 8 also discussed how HR departments do not disclose employment contracts to HSPs. It was revealed that some HSPs could not even take sick leave. At the managerial level, officers and director' refusal or inability to discipline malpractice, provide effective training resources and tackle pay disparity and corruption contradicts

their supposed commitment to helping staff provide SRH services. For instance, the financial status of HSPs who were receiving their salaries from MSF was better than other HSPs who were only receiving salaries from MoPH. One of the reasons that HSPs in Dashte Barchi district hospital asked for a fee of service from patients, especially during childbirth, was the low MoPH wage scale. This in turn contributed to patients' reluctance to attend health facilities and seek SRH services, which may have resulted in higher maternal mortality and morbidity ratios.

This data suggests that enhancing the higher quality of health service provision probably begins with senior health staff treating the HSPs in the same manner that they would expect them to treat patients. This means showing them respect and valuing them as people. It also means enhancing their own mental health and psychosocial wellbeing, improving the reliability of adequate income and including them in capacity building programs.

Evidence from countries (e.g. China Pakistan Mongolia Burundi and Northern Uganda) suggests that implementing socially acceptable and friendly facility-based intervention can change organisational environments, and increase the SRH uptake of services despite reported failures in some low and middle-income conflict-affected countries (Denno 2015, Chi 2015, Mumtaz 2003 & 2014, Sovd 2006, Berhane 2005, Chao-hua 2006, Mumtaz & Salway 2009).

Another study identified 4 complementary approaches to increasing SRH service uptake. These are: Training to encourage non-judgmental and friendly behaviour by HSPs, an engaging and friendly environment at health facilities, communication, knowledge transfer and outreach activities for the reinforcement of SRH uptake, and support from the community for SRH service provision (Chandra-Mouli 2015). In contrast, efforts in Tajikistan and Kyrgyzstan to educate HSPs in improved doctors-patients communication, ANC awareness and higher quality SRH services failed because the HSPs level of knowledge around ANC /PNC and childbirth complications was too poor (SDS 2013). This implies that complementary approaches can be applied in conflict-affected settings like Afghanistan as long as social aspects and cultural acceptability are considered and interventions are based on accurate assessment of HSPs knowledge and skill levels.

The discussion to date assesses adequate levels of staffing. In the 4 cities, in the Eastern and Western districts of Kabul, staffing levels within the health facilities

varied. For instance, Dashte Barchi DH had insufficient numbers of HSPs (41/700,000 populations). Conversely, Ahmad Shah Baba DH, which is supported by MSF, had more resources (260 MSF and 52 MoPH/ 350,000 populations) but still could not sufficiently provide health services to all patients who attended. The overarching under-servicing I have detailed is not indicative of the true extent of limited provisions. Many women do not access SRH facilities at all. Women who cannot attend the health facilities due to insecurity, poverty and sociocultural norms, need the support of skilled community health workers (CHWs) or skilled birth attendants (SBAs). However the research data indicates that there are insufficient health resources in more remote areas to allow the provision of higher quality SRH services.

In practice, SBAs and CHWs currently often have no effective role in the communities, since many mothers in-law tend to support home-based childbirth due to monetary, security and cultural issues. A community-based intervention undertaken by Sarkar (2015) in low and middle-income countries (India, Malawi, Nepal) revealed that national reproductive health programs and multilayered-interventions for improving outreach activities, HSPs and community health workers' capacity building and counselling could increase reproductive health service uptake. This particular project did not include access to safe abortion and delaying first pregnancy, nor could any such community-based projects in Afghanistan, as doing so currently would undermine the social acceptance of outreach programs.

Some authors argue that in order to improve the uptake of SRH services, health provider-centered systems should be converted to a patient-centered system and address issues around honour and valuing patients' rights, privacy and informed choice (Sarkar 2015). They also argue that HSPs need to be educated around higher quality SRH service provision, and that with a strong commitment they could transfer knowledge into practice. Such recommendations could be challenging to implement in Afghanistan, however as they often fail to address the social power dynamics within 'Heteronomy' (Sariola & Simpson 2011). Such recommendations would also fail to consider the ethnic diversity within and between communities, particularly within Kabul.

Health service providers face many challenges when dealing with patients from different ethnicities. Since every provincial dialect is different from the national standard languages, it is often challenging for HSPs to understand what patients are talking about. Thus there is a need for language training for HSPs because better

language skills are essential in order for HSPs to communicate properly with patients and improve effective SRH knowledge.

Munro (2007) assessed eleven 'Behaviour Change Theories' and found that the 'Communication Perspectives Theory' suggests that communication skills improvement between HSPs and patients enhances health service uptake adherence. The focus primarily was on the length of treatment, comprehensive instruction and health service uptake (Denno 2015, WHO 2013d). Another review by WHO (2003b) also demonstrates that improved communication enhances HSPs practice and patients' satisfaction. In fact, the 'Communication Perspective Theory' should be used as a component of other adherence interventions. Application of this theory can not improve HSPs' long-term behavioural change alone unless integrated with other approaches, such as improved organisational management and communication, HSPs communication skill training, continuity of care and ongoing communication e.g. telephonic contacts and social support.

Patients often mistrust the treatment or diagnosis of HSPs in public health facilities, and instead utilise private sector health services. It means that sometimes access or uptake of SRH services is not limited for particular groups of women, but services are misused. For instance, we discussed that how women tend to undergo several ultrasound examinations in order to confirm the gender of a baby. This is an over utilisation of such an expensive service and an underutilisation of more useful and cheaper services like the ANC and PNC.

In this research, there were numerous female participants who were victims of physical, verbal and behavioural violence over their life cycle. According to the data, violence and abuses are pervasive throughout society. Women routinely experience violence from males and their own gender within their homes. As members of the same society, HSPs share similar cultural beliefs and experiences and take wider cultural values into the workplace and play them out in a highly pressured work environment. Their personal values and experiences influence their beliefs about other women and acceptable behaviour within the workplace, and contribute to an abusive and judgmental atmosphere within health facilities.

The findings revealed that a lack of honour and knowledge about patients' rights, medical ethics and workplace professionalism influence HSPs violation of what WHO and other societies would regard as women's obstetric and

reproductive rights. During my participant observation in district hospitals and comprehensive health clinics, HSPs' abusive, judgmental behaviour discouraged patients from seeking proper sexual reproductive health services. Their stories discouraged other women in their families and communities from attending health facilities unless they were desperate. In my research, many patients were not believed or respected if they complained about their health concerns or requested particular services. Across ANC and PNC, childbirth and FP sections, women confronted abusive and judgmental behaviour from HSPs. Whether it was simple personal details, such as their age, specific symptoms or reasons for contraception, many HSPs labeled patients 'liars', 'fools' and 'manipulators' and often called them 'stinky' or 'unhygienic.'

The comments that I witnessed were shocking in themselves, but they could be even more devastating if they are attributing moral failure to women who are actually suffering from undiagnosed or untreated health conditions. For instance, there might have been some cases of obstetric fistula. It is one thing for women to be too ashamed to talk about, but it seems that HSPs did not recognise this possibility either. Literally nobody (neither the women nor the HSPs) ever discusses obstetric fistula or its complications or consequences. It seems that it is either not understood or too taboo to discuss. In addition some HSPs knowledge is questionable in term of routine practices and their debates about diagnosis of a patient's (267) prolapsed uterus.

Such conditions are not unique to Afghanistan (El-Nemer 2006, Spangler 2011, Mchome 2015, García-Moreno 2014, Flávia 2002, Browning 2014, Jokhio 2014, Imoto 2015). However Afghanistan is more religiously conservative than many other low-income nations, and its people have also suffered from decades of brutal war, violence and extreme discrimination against women, which would also increase the likelihood of mental health issues amongst people, including HSPs.

In the Afghan context, strategies to address the mental health issues and prevention and support for the victims of violence are needed both for patients and HSPs and the changes to health facilities are unlikely to be effective without broader multi-sectoral intervention. Interventions to address such patterns of violence have been tried elsewhere (WHO 2013a & b, Vieira & Almeida 2009, Usta 2007, 2012 & 2014). For instance, in Lebanon, a 'Human Rights-based' action-plan was developed with the aim of responding and protecting GBV survivors and improving referral pathways at primary health facilities. The Ministry of Social Affairs in Lebanon implemented

national programs to increase GBV awareness and seek HSPs support. Moreover, their Ministry of Justice with the coordination of many entities enforced the law for protection of GBV survivors (UN-ESCWA 2013, Usta 2014). The training of HSPs to respond to GBV cases was enforced. However HSPs were still reluctant to provide adequate support to survivors because social, cultural, political and religious sensitivities existed in Lebanon and it was first believed to be a domestic issue. Additionally, and unfortunately, these programs seem unaware that in Afghanistan at least and other conflict-affected states the HSPs who are central to the referral pathways may be in need of help themselves (as mentioned previously).

Likewise, in Afghanistan, some HSPs still blame survivors (Usta 2014, Bhate-Deosthali 2012 & 2013). In another study of global maternal health researchers, respondents addressed the need to alter health professionals' abusive attitudes among themselves and towards patients in order to achieve higher quality health services (Kendall & Langer 2015). In chapter 8, however we learnt that some of the violence, abuse and lack of care and service is not the result of personal experiences of violence, nor is it due to lack of medical knowledge and effective training. Some of it has to do with religious and/ or moral beliefs. Statements about 'sin' in terms of permanent contraception and abortion are not necessarily demonstrations of ignorance about reproductive functioning so won't be resolved simply by providing adequate mental health support and presentations of scientific facts or knowledge.

Violence of rights also occurs in less tangible ways, such as the absence of patients' privacy and confidentiality in health facilities. Many newly wedded girls are brought to health facilities for virginity examinations. HSPs check the virginity without the consent of the new bride. If it is confirmed by HSPs that the girl is not a virgin, everybody including HSPs and family members, blames the girl. It can be argued that firstly, HSPs go against the patients' privacy and honour, and the self-esteem of the girl comes under attack. Secondly, there are different types of hymen, but as far as I know, no medical training (either university or teaching hospitals) teach HSPs how to diagnose virginity and the causes of recently ruptured hymen. In fact, there is absolutely no standard procedure for it. The consequences of a wrong 'diagnosis' for the new bride can be life threatening.

It can be argued that lessons from Lebanon, which shares similar cultural and religious beliefs, and has developed a 'Human Rights-based' multi-sectoral action-

plan in relation to GBV can be replicated in to the Afghan context. This approach would seek to improve referral pathways at primary health facilities, increase GBV awareness and seek HSPs support through the Ministry of Social Affairs and also enforce the law for the protection of GBV survivors through the Ministry of Justice. Additional support for HSPs, who are themselves suffering from GBV, needs to be included.

10.1.3. Factors Affecting SRH Service Uptake At The Individual Level:

The research sites, both in the Eastern and Western districts of Kabul, were very settled, with the majority of research participants coming from poor socioeconomic backgrounds and arriving at the health facilities by local buses or walking from 74 districts and sub-districts to obtain health services. Often they would spend a minimum of 5 hours away from home in order to access the services.

A small number of participants who were living close to the Ahmad Shah Baba DH had better access to the social determinants of health than the majority of participants in Dashte Barchi, Bagrami and Pul e Khoshk. These participants were more likely to have more safe drinking water, hygienic sanitation, some level of education, paved roads, healthy food, electricity, and primary health services etc., than other participants. Some of the factors behind this differential access to SDH are long standing and interconnected due to civil war, poverty, patriarchal values, gender inequalities, communication and knowledge gaps and discrimination against women.

It would be difficult to address all the social factors around Afghan women's life cycle, but simultaneously there are some key points to point out. The research findings indicate that along with other social factors, protracted war and poverty exacerbate the burden of health issues, and have a negative effect on the physical and mental health of Afghans, particularly women. It was discussed in the Afghanistan context overview that almost half of the Afghan population lives in multidimensional poverty. In many surveys, it is reported that male members of the family could hardly find a decent job and their average daily income is lower than 2 US Dollars a day. As a matter of the fact, insecurity and joblessness has forced many people to flee from the provinces and live in communal poor housing and sanitation on the outskirts of Kabul.

Understanding of the social factors and interpersonal dynamics behind the poor health of women is essential. Some research papers have applied the 'Social Ecological Model' in many countries (Malawi, USA, Saharan Africa, Kenya, Nicaragua, Brazil, India etc.) to explore the interconnectedness of environment and adolescent SRH (Gombachika. 2012, Shelley 2010, Raneri & Wieman 2007). For instance, Raneri and his colleagues (2007) evaluate the impact of complex factors on multi-pregnancies in the USA through this model. Svanemyr (2015) addresses the issue of poverty in low-income countries. Under this model, which impacts on women's autonomy in decision-making, movement and self-

esteem, he states that allowing more girls to acquire secondary education and offering microcredits to start small businesses, or gaining vocational skills, boosts women's self-confidence, esteem and value. Additionally creating judgment-free and confidential environments in which to improve knowledge about puberty, age of marriage and SRH service uptake and remove barriers between women and HSPs, would also be helpful (ibid).

However the application of the 'Social Ecological Model' and the achievement of significant SRH outcomes from it will be difficult in Afghanistan, where social norms impede communication of SRH at household and community levels. If applied in Afghanistan this model would require more understanding across a wider aspect of female development and not just in the years when females become sexually active.

In chapter 7, 'Life-cycle of the Afghan women', we learnt that many social factors impact on women's health seeking behaviour. Sexism against women is an issue that patriarchal societies like Afghanistan have to deal with. Son preferences and perceiving girls as a liability results in such stigma against girls that the birth of a girl is routinely not celebrated. A large proportion of younger women are dominated by their fathers, brothers, husbands and mothers-in-law and the lack self-confidence and decision-making power to decide for themselves and the size of their family, child spacing and access to health facilities. They experience shame and lack of honour and respect for their physical and emotional needs as women.

Multifaceted data reviews highlight how girls' education levels have an influence on their level of health-seeking behaviour and SRH knowledge (Egmond 2004, Kendall & Langer 2015, Mumtaz 2003, Chandra-Mouli 2015, Ackard 2006). However pubescence for a large number of my research participants was the trigger for the end of studies, movement out of confines of the household and the beginning of a new phase of their lives. It is noted that although parents can socialise their children in Afghanistan SRH related information is discussed neither by parents nor peers at the school.

In Afghanistan there is an ingrained mindset that Afghan girls will only learn about their sexuality when they are married. It is noted in the Afghan women's life cycle section that parents and adolescents often feel too uncomfortable or shy to discuss SRH related issues. This culture of silence around sexuality leads poor levels of communication between parents and adolescents, unawareness and poor SRH

seeking behaviour. Thus it can be argued that family members, especially parents, can play a significant role in terms of communicating SRH with adolescents, because the foremost barrier, apart from sociocultural norms, is lack of SRH knowledge amongst parents.

It is pointed out that education is a key way of improving girls' mental and physical abilities (UNICEF 1990). However in the Afghan context, the social practices of marriage force young age girls to drop out of school and start a married life. Shaw (2009) discusses in her article, that delays in marriage do not reduce sexual activities but increase the demand for SRH service uptake. In contrast, a different scenario in Afghan society shows that delays in marriage do not impact on SRH service uptake, because even if Afghan girls wish to access SRH services after marriage, they often cannot due to insecurity, poverty, distance from a health facility, lack of communication about SRH and more importantly, a lack of decision-making power.

The Afghan Women's diminished economic and social status compromises their ability to select a safer and healthier life-style. In addition, lack of trust and honour at the household and health service provision levels impact on women's health seeking behaviour. For instance, a newly married girl needs to prove her virginity on the wedding night and fertility in the first year of marriage. She also needs to prove her reproductive value by producing a baby boy before she is allowed by her husband or a mother-in-law to have an institutional childbirth. At the health provision level, she has to demonstrate her menstruation blood in order to obtain contraceptives, or prove that she is in labour to be admitted to the hospital. Failure to provide evidence leads to various types of violence, persistent pressure and stress.

Compared to other countries, the levels of entrenched violence, gender imbalance or power seem to be much higher in Afghanistan than elsewhere. This may be partly the outcome of having been through long and brutal wars. Mistrust and violence have been imprinted into the bones of social, religious and familial values. Contrary to what was perceived at the beginning of this research, my research shows not all violence is GBV. Evidence from numerous participants revealed that female-to-female violence exists within households and health facilities. The data shows a double standard within the Afghan families and society when it comes to a female sexuality, because on the one hand, communication and education around SRH issues are taboo but on the other hand, mothers-in-law and other female members of the household check on

virginity of newly married girl and control her sexual activities, pregnancy and child-spacing.

Afghan culture, family relationships and people's beliefs have created a condition where women do not possess the power or courage to discuss their sexual diseases and/or issues with husband. In contrast, the mother-in-law and other elderly women in the household play a substantial role in relation to female family members' sexuality, SRH and health seeking behaviours. Contrary to my perceptions before conducting this research, mothers-in-law actively help women with her pregnancy related issues, support home-based childbirth and manage post childbirth complications by drawing on their experience and use of home remedies.

A substantial proportion of women reported that they did not complain about their health concerns to husbands, parents, in-laws or other family members in order to maintain their dignity and value as a healthy woman and avoid being as an ill woman. A large number of women who do complain about their health issues to husbands or other family members and HSPs, find their health issues are usually overlooked and remain unacknowledged. In both cases, the health and well-being of women is devalued.

In Afghan households and society verbal, physical and behavioural violence is deeply ingrained, accepted and commonly practiced. My research also suggests that coerced and unsafe sex, especially during pubescence, periods or post childbirth, is fuelling violence against females and increasing STIs and mental illness among women. The combination of unawareness about SRH and the associated pervasiveness of pornography is aggravating these factors and sexual coercion. Most people think that sex is for enjoyment of men, not women, and it is a women's duty to fulfil her husband's needs.

Indeed, access to smart phones and pornography is increasingly influencing a large proportion of men's sexual behaviour and leading to sexual violence. Afghan men learn about sexuality through watching pornography and they routinely force women do what they watch on porn clips. This relationship is not unique in Afghanistan. Numerous studies indicate the correlation of smart phones and pornography with interpersonal violence (UNESCO 2009a & b, Chao-hua 2006, Brown 2006, Mohammadi 2006). In a study of German heterosexual men for instance, it is demonstrated that exposure to pornography increases the likelihood of men coercing

women into sex. They enjoy dominant behaviour and verbal, physical and sexual violence (Wright 2014). My results suggest, however that sexual violence against women may be more extreme, common and /or acceptable in Afghanistan as a result of the pre-existing denigration of women and the normalisation of violence through years of conflict.

It is significantly important to mention that men play a crucial role in improving SRH because they have more access to the media, TV and newspapers. In addition men are more economically independent and tend to communicate more easily around SRH. Therefore making a virtue of their access to media (TV, radio and newspapers) may have a positive impact on their health seeking behaviour change. For instance, in a study of Bangladesh, Pakistan and Thailand, men's culturally sensitive education and 'men-friendly' reproductive health service facilities were successful in terms of contraceptive uptake and community outreach (Sternberg & Hubley 2004, Shahjahan 2013).

In 2014 it was stated that half of the global population used mobile phones for communication and that 55% of 3 billion Internet users are from developing countries. By 2020 it is estimated that the growing broadband connectivity will create 6 billion Internet users (UNF 2015, MICT 2015). In response to such widespread use of phones, the WHO guideline provides a practical resource for 'mobile Health' (mHealth) service providers. The mHealth service provides guidance for public and private health sector partnerships between mobile network operators (telecommunication companies), government and implementers and joint investment in mHealth service. Since SRH and reduction in maternal mortality and morbidity is prioritised globally, mHealth initiatives pave the way for women's health and wellbeing improvement (ibid).

Mobile Health services (mHealth) consist of text messages aimed at reducing maternal mortality and morbidity (in South Africa and Kenya text messages remind women and their families about ANC visits). After successful programs in Africa, in Indian state of Bihar new software (MOTTECH) was developed and applied to mobile phones to provide health education for women, family members and improve communication skills among CHWs (MICT 2015, USAID 2015, Franz-Vasdeki 2015). Mobile phone advertising or SMS is a very effective intervention in terms of health promotion. Numerous study results demonstrate a positive outcome, mainly behavioural change. For instance, a study was conducted to evaluate the

effectiveness of mobile phone texting systems to evaluate the sexual health knowledge and behaviour improvement and sun exposure avoidance in Australia. Those subscribers who received text messages demonstrated considerably greater knowledge about safe sex, condom use and testing for STIs. Although such advertising companies to young people, who continue to use mobile phones, is a new and better approach than TV, radio, billboards (Lim 2008, Munro 2007, WHO 2003b, Gold 2011).

In Afghan society, mobile health (mHealth) service could be an effective method, of awareness rising especially where the majority of population is uneducated but possess a mobile phone. In addition, it particularly helps those women who are unable or not allowed to go to health facilities to learn self-care and contact a CHW in case of any health complications. Mobile phone messages aligned with religious and sociocultural beliefs can increase people's SRH knowledge, self-health management and health promotion intervention. All text messages prior to being sent to the target population should be designed with the aim of improving people's SRH seeking behaviour and knowledge.

There are social boundaries for women's access to health facilities. Many people, especially men, judge girls and women's appearance. Irrespective of what type of clothes they wear, some men or boys just look for opportunities to humiliate or molest women or girls on the road. To avoid such humiliation, husbands and in-laws can hardly trust women to access health care services alone. In light of the research aims, there is a need to increase social awareness around honoring and avoiding judgmental behaviour instead of restricting girls or women's movement to schools or health facilities.

The application of a 'Comprehensive Sexuality Education' (CSE) model in different cultures can increase understanding of sexuality and improve sexual health seeking behaviour (UNFPA/AFG 2012, Chandra-Mouli 2015, Blum 2012, WHO 2014a, Lou 2004 & 2006, UNGA 2012, Germain 2014). This model also enables adolescents to learn about their bodily changes, use of condoms or contraceptives and prevention of STIs transmission. It also boosts adolescents' confidence to communicate about SRH and build autonomy elsewhere (ibid).

Youth friendly services and CSE have been proposed and implemented with considerable coordinated management and harmonised efforts in many countries e.g.

Sub-Saharan Africa, Egypt, Nigeria, India, Pakistan, etc. (Chandra-Mouli 2015, UNESCO; 2009a&b, Haberland & Rogow 2015, UNFPA 2014-15b, Braeken & Rondinelli 2012, Mmari 2003). However youth centers, peer education and public meetings have been ineffective in terms of SRH knowledge, attitude, behaviour, trust and beliefs (Chandra-Mouli 2015). A growing number of countries, including, Tanzania, Mexico, China, Kenya, Lebanon, Nigeria, Vietnam, Latin America and Caribbean etc. have incorporated the CSE model into the school curriculum and transferred knowledge to young peoples through teaching sessions, media, school, and billboards (UNESCO 2008-9, Chao-hua 2006). Most curricula addressed puberty as biological change but social challenges, such as increased vulnerability to risk were not discussed (Chandra-Mouli 2015). Although the content of curricula were age-appropriate, inclusion of information around puberty, sexual rights, gender-based violence and intimate partner violence was overlooked (UNESCO 2009, Chao-hua 2006, Chandra-Mouli 2015).

In two studies, CSE has improved knowledge, attitude, practices and health seeking behaviours (KAPB) with effective SRH services. However, sometimes only a few elements of CSE have been implemented, instead of the whole package. For instance, since 2010, those Iranian couples that are planning to get married and obtain their marriage license, need to take a four-hour, mandatory sexuality education class. However access to fundamental CSE is overlooked due to Iranian religious and cultural beliefs (Zand 2013).

In Afghanistan, there is only one single youth support centre in the entire country where adolescents can call to obtain SRH information, without the shame of face-to-face contact. The Afghan Family Guidance Association (AFGA) is financed by UNFPA and supported a 'youth health line' pilot project. This project only reaches a small proportion of people and is not big enough to cater for all to adolescents' SRH needs (UNFPA/AFG 2012).

The 'youth health line' pilot project was initiated to advise adolescents about sexual issues. However the counsellors who respond to the telephone calls, have to deal with abuses and social discrimination. Resistance to SRH 'Youth friendly' programs and 'comprehensive sexuality education' increases the gender inequality gap and women's vulnerability to SRH issues (Yang & Gaydos 2010). The reason for resistance could be that in the Afghan context, there is no specific institution to set up to provide a longer term comprehensive sexuality education aligned with the Afghans

faith, culture and social beliefs. Therefore, it is difficult for young people, including couples and especially married women, to access such programs, even when these programs do exist.

The implementation of sexuality education intervention for both men and women would reduce adverse consequences of poor communication and knowledge, mistrust and lack of honour and improve access to SRH health knowledge and higher quality services. However in Afghanistan, where the total literacy rate is 47%, it would possibly reach only a small proportion of people who have access to school. The 76% of the population who lives in rural areas might not benefit from this intervention. Ideally, integration of other interventions with CSE would help address poor SRH service uptake.

Multi-interventions were utilized to address gender equality, for instance, a gender-neutral program identified men's and women's needs and gender roles (Barker & Ricardo 2007 p.76, SRI 2012). In fact, sexuality education is a 'human right-based' approach which can be provided to adolescents and adults with age-appropriate, culturally acceptable added religious values and scientifically factual information. As society as whole becomes more knowledgeable about sexuality and SRH, all members of the society should be able to hold knowledgeable discussions about safe sexual activities, prevent unwanted pregnancy and avoid STIs, make informed choices and reduce the scale of sexual violence and incidents of coerced sex.

In chapter 7, I discussed how women in their aging phase of life gain more decision-making power in the household and usually play specific roles in relation to SRH issues (pregnancy, contraception and childbirth) and the health seeking behaviours of other female members of the household. On reflection, it was apparent that the SRH needs of aging women, particularly those going through menopause, are completely excluded from the formal policy process and seem to be rarely discussed in social and political spaces or households.

Therefore, indicators of sexuality knowledge and communication gaps, social practices of marriage, household power dynamics, high fertility rates as a consequence of son preferences and limited access to education and sexual reproductive health services, interpersonal violence and diminished level of trust and

honour were useful for a better understanding of the extent of women's vulnerabilities at an individual level.

During the last 20 years, many universal and culturally specific interventions and approaches have been applied in many countries in order to improve SRH service uptake (Chandra-Mouli 2015, Blum 2012, WHO 2014). Concentrating on universal approaches raise questions around what kind of SRH should be utilised in different cultures. Even if a comprehensive RH or SRH rights educational program is not construed as a Western paradigm within Afghanistan, there are other sensitivities about such policies and programs, which means they may not work.

Many countries are committed to applying SRH and rights in practice. However evidence demonstrated that due to the sensitivity of the health system level, the Afghan RH Policy might not be fully implemented because the standards elements of sexual health and human rights are overlooked. It would be essential for policy-makers and senior health staff to identify and replicate culturally accepted SRH awareness Policy, Strategy, and Guidelines from similar cultural and religious background and contexts. For instance, they could review the Lebanon and Iran SRH Policy and Guidelines.

During my fieldwork, I came across some positive interviews that gave me rays of hope that these participants' positive experiences of life and SRH seems may improve uptake in Afghanistan. Men's positive perceptions impact on other men. I believe these men are in a position to act as role models in society. In a war-affected or fragile context like Afghanistan, where people value their beliefs and practices, effective implementation of SRH interventions will be resisted during the early stages. Although it is time consuming to change people's health seeking behaviour, as individuals we can bring about small changes and turn the negative consequences of life into positives.

10.2. Recommendations:

The aim of this dissertation was to begin to identify many possible interventions, which will overlap sectors, levels of responsibility, short-term and long-term etc. It is not easy to always delineate between why and where they may be best targeted. Lessons can be learnt from effective SRH interventions in countries with similar sociocultural backgrounds. However each conflict-affected country is distinctive in many ways. In a complex health system, recommending solutions requires distinctions to be made between types of problems and applicable interventions for the complex Afghan RH system in short, medium and long-term propositions.

Many of the RH related problems require long term planning and actions, greater security, economic growth and greater availability of national funding. In addition, research, survey, quality assurance and surveillance system is crucial for reinforcing the SRH recommendations. In the current situation one approach is to start with short-term actions. Smaller actions together may build across the health system without large, costly interventions require resources, which the MoPH does not have. We need to walk slowly and constantly to achieve success if we run fast we may lose our way or support, and then we slip.

In this section, I will recommend some applicable interventions related to my research findings (communication, knowledge, trust and honour). I will begin with recommendations in a specific time-scale at the health system level.

10.2.1. Recommendation at the Health System Level

Medium-term Actions

- Civil Registration System and Electronic National Identity

A Civil Registration System (records of births and deaths, marriages) should be located within the health facilities and legislative offices where marriages are registered. In the rural areas, where the majority of births, deaths and marriages are not registered, the MoPH through (male and female) CHWs could expand the registration process. Moreover, patients' marriage and birth details can also be registered, as a routine part of ANC/PNC care. This action would help the Central Statistics Office (CSO) to obtain factual statistics instead of estimating birth and death

ratios. If the MoPH in collaboration of Ministry of Justice (MoJ), Ministry of Hajj and Religious Affairs (MoHRA) and Ministry of Communication & Information Technology (MCIT) enforced the distribution of electronic national identity and registration of marriage, the long-term outcome would be improved measurements of life expectancy and delay young age marriage.

- Enhancing Surveillance System

This is a key action point. The HMIS system can be strengthened through the digitalization of health facilities' reporting systems and database management. In order to create an accurate census of birth and deaths in remote areas, the RHD could recruit community health workers (CHWs) and set up a system through which they could directly report home-based childbirth to the HMIS office. Thus, a proper surveillance system would help the MoPH/RHD to evaluate the health facilities' routine practices and identify the burden of SRH issues and women's health needs, and take necessary actions to decline in MMR, pregnancy and childbirth related complications.

- Monitoring and Evaluation (M&E) and Quality Assurance

Quality Assurance, which includes evaluating organisations' process and performance outcomes will provide information required to identify where best to make changes. Since the observed health facilities' management appears to be failing, monitoring and evaluation of routine managerial activities would help prevent failure or inadequacy of organisational management and work standards. To avoid the disparity between similar and/or complementary SRH projects' activities, sharing through the benchmarking of M&E process and outcomes could be initiated. Benchmarking activities should encourage and strengthen multi-sectoral coordination amongst all relevant RH departments, donors and implementing organisations. Such initiative could start small, say in one province such as Kabul, and positive SRH outcomes of national and international implementing organisations' activities could then be replicated in other parts of Afghan context. Once successfully dispersed across the provinces, the activity reports could also be used to identify where national needs are most urgent.

- Sustainability of SRH Projects and International Funds

Evidence demonstrates that monetary support does not guarantee sustainable SRH projects. Sustained political commitment, inclusion of all SRH needs in the political agenda, proper financial and management planning and multi-sectoral commitment

would improve a broad and equal access to SRH services. Hence, the MoPH in collaboration with international donors could also plan for capacity building with national HSPs (doctors, midwives, nurses, vaccinators and laboratory technicians) both in the cities and remote areas. In addition, international funds could be allocated for the procurement of medical equipment, expansion of health facilities and health promotion programs in remote areas, particularly in districts of Kabul where a larger proportion of displaced people have no access to health facilities,

To reduce concerns over the reduction of external aids for the SRH programs due to increased levels of insecurity in many provinces of Afghanistan, the MoPH could build the capacity of health staff through the expansion of telemedicine technology system from the capital to district and provincial health facilities. The expansion of this program would help health staff to transfer and exchange knowledge with other experts at the national and international levels.

Moreover, the involvement and support of the private sector for sustainable and accessible SRH services will be crucial. In addition, it would fill the gap for health resource shortages to some extent. For instance, the recruitment of midwife graduates from private educational institutions could fill the gap of insufficient graduates from public institutions.

Review Similar Contexts' Effective SRH Interventions

In a medium-term action, MoPH can include SRH in the political agenda and to review effective SRH interventions from similar contexts such as Iran. This action in a long-term scale would help policy-makers to have ownership of their own ideas and better chances for application of socially acceptable interventions to improve SRH service uptake. Thus, more effective dialogue results in more commitment and collaboration.

- Professional Ethics Enforcement, Discipline Malpractice and Corruptions

Operational standards and professional ethics for SRH services should be enforced in order to prevent the disparity of health services. As in the current RH system in Afghanistan violence and judgmental behaviour are justified and patients' rights are not considered important, radical action could be taken to increase accountability and a greater emphasis on medical professional behaviour. The RH directorate and other decision-making authorities can design capacity building training programs to enhance HSPs knowledge and accountability for medical professional behaviour,

patients' rights and privacy and professional commitments for higher quality SRH service provision.

A 'patient-centred' health system would improve women's SRH service uptake, actions and attitude demonstrating honour and value via patients' rights, privacy and informed choice. Such a change would be extremely challenging in the Afghan context since verbal, behavioural and physical violence is also practiced at the health facilities. Some of this behaviour however results from low wages and lack of appreciation. These are the aspects that the MoPH/RHD could directly have an influence on motivating HSPs for improved work outcomes. Other actions they could take are: professional behavioural training, ensuring HSPs annual leave and promotions, reductions of workload and provision of psychosocial counselling support.

Long-term Actions

- Security and Poverty Reduction

This is essential for the population's health improvement and accessibility to SRH services. Many SRH related interventions are associated with the emergence of peace and stability in Afghanistan, which will be a long-term process. There are still numerous interventions that could be applied, even given the current circumstances but they would be less effective than they might otherwise be. Poverty and insecurity add to the social pressure on parents to value sons over girls, reject girls schooling and marry their daughters at a young age. Moreover, many women due to both poverty and insecurity are not allowed to go to a health facility, so they suffer in silence. The improvement of economic status and stability would remove some of these incentives and stimulate private providers to expand their services. Both efforts should improve SRH service uptake in the longer-run.

- Behavioral Change and Communication/ Information Education and Communication (BCC/ IEC)

Improving communication and behavioural change would be started from the RHD office. It can be suggested that at the SRH system and inter-departmental levels discussions and regular dialogue between both male and female governmental employees and health professionals would facilitate knowledge transfer and fill in knowledge gaps.

The involvement of men in SRH policy-making levels would be effective because sexual health issues are the shared concerns of men and women. In addition, the engagement of main stakeholders (religious leaders, community members, health and educational professionals, ministries (health, women affairs, justice and education) can help change cultural beliefs and detrimental social practices that lead to son preferences, young age marriage, lack of access to school and health facilities, home-based childbirth and multi-pregnancies. Likewise, mass media campaigns, SRH dialogue and debate through TV channels, radio, billboards, aligned with additional advocacy programs, would help to increasing people's confidence to communicate about SRH issues and reduce sensitivities.

The above recommendations sound easy but it must be recognised that HSPs are also members of the same society and share similar sociocultural beliefs. Designing socially acceptable SRH advocacy programmes, developing leadership and effective planning and training at the health facilities to encourage effective SRH communication will take time, especially given the poor mental health of staff. Only gradually such activities would reduce HSPs' reluctance and embarrassment in conveying SRH related messages to patients.

- Comprehensive Sexuality Education and MHealth

MoPH/ RHD can design effective and socially acceptable 'Comprehensive Sexuality Education' programmes with collaboration of Ministry of Communication & Information Technology (MCIT) and Ministry of Education (MoE). To apply mHealth intervention, partnerships between public and private mobile network operators and health sectors would promote the use of mobile phones to increase people's awareness.

Comprehensive Sexuality Education (CSE) can be adapted from countries with similar socio-cultural background to fit in with national education Policy and strategic framework, although this approach will be limited to those adolescents who have access to schools. However adopting this intervention would allow policy-makers and RHD staff to begin understanding these interventions from diverse perspectives. Such programs would initially be very controversial and would require the cooperation of the private sector, MoE, and school staff.

Ideally, the CSE would address poor SRH service uptake, better SRH knowledge and communication between community members, especially gatekeepers, including religious and community leaders through public education or awareness programs,

which has a long-term impact in terms of behavioural change. It would also open up the doors of communication amongst couples to discuss about SRH services (ANC/ PNC visits, childbirth preparedness and contraceptive) uptake and access to health facilities.

10.2.2. Recommendations at the Health Service Provision Level

Short term

- Mobile Clinics

A large proportion of people have been displaced from many provinces of Afghanistan to Kabul due to poverty, joblessness and insecurity. In a short-term action, the RH directorate could provide SRH mobile clinics to the people who are not in a position to reach Kabul health facilities. Activities could be linked to education about hygiene, the importance of ANC/ PNC visit, birth preparedness and institutional child-birth, family planning services and SRH promotion programs, and even the positive consequences and benefits of girls in schooling. In addition, to prevent young age marriage, unintended pregnancy and abortion and violence, there is need for a comprehensive SRH education for youth, particularly out of school adolescents. This action should not only increase access for poorer or more distant people, but also could reduce overcrowding in district hospitals and comprehensive clinics.

Medium Term

- Switching From a Bureaucratic Health Service Provision to Digitalized System

The bureaucratic system creates unnecessary paperwork for HSPs, which often hinders health service providers' face-to-face communication with patients and building trust. There is a need for a robust organisational work and health service provision planning in order to bring about a constructive change in women's health seeking behaviour and improve SRH service uptake through proper routine health practices and high-impact services.

Within health facilities improved SRH knowledge and communication skills in HSPs routine practices are required. Since the bureaucratic system and time pressure widens the distance between HSPs and patients, reducing paperwork from various sections of health facilities could give HSPs more time to spend with patients and perform their routine practices more effectively.

- Discipline Malpractice and Corruptions

Operational standards and professional ethics in SRH provision level should be enforced. Since corruption undermines SRH service provision, there is need for a strong organisational management, enforcement of professional standards and disciplining of malpractice and corruption in the health service. For instance, transparency in employees' contract details, a gesture of appreciation and some incentives to avoid corruption would encourage HSPs to enhance their routine practices and deal with patients in a decent manner, without asking for a fee for services or bribe.

- Male Involvement

Including men's sexual health needs in the RH policy could easily highlight the contribution to the importance of males SRH awareness. Educating men about STIs and how to avoid them should also protect more women from STIs. It may also enable them to be more comfortable discussing SRH with women, especially their wives. This may also enable women to communicate about their SRH needs, particularly in terms of contraceptive uptake, ANC visits and institutional childbirth. Since there is a shortage of health staff, it would be effective if male HSPs are recruited and trained to respond to the SRH needs of men and also part take in SRH awareness programs. Male nurses and community health workers (CHWs) working with female nurses and CHWs could provide counselling to couples in terms of pregnancy complications, birth preparedness, FP and mental health.

- Task Shifting and Community Health Workers (CHWs) Participation

In rural or very poor communities, the expansion of Community Health Workers (CHWs) role is vital. For instance, providing delivery kits to mothers-in-law and training them about childbirth preparedness and quick decision-making in terms of pregnancy or childbirth complications. Lessons can be learnt from one of the NGOs (Health Net TPO), which apart from provision of ANC/PNC and FP services in the provinces use community mobilisers to recruit couples from communities and train them jointly. In this way, this organisation improves community members' knowledge about SRH issues and promotes equitable gender attitudes. These CHWs do more than providing health awareness to the community members. They also assist them to become self-reliant through skill sharing. For instance, if one woman is able to do hand embroidery she could help other interested women to learn it and help their families financially. In general, Health Net TPO is providing SRH and Rights

awareness, and teaching income generation skills to men and women in their localities. Although they do not describe their work in this way, it is actually a successful demonstration of an 'Asset-based' approach.

- Absorption of Medical Resources

Absorption of medical resources (midwives, nurses, lab technicians and doctors) from private institutions would promote SRH service provision in remote areas. Increasing in the number of health educators would increase SRH awareness amongst people who have no access to health facilities. In addition, job creation at the community level and training of CHWs not only provide financial support to CHWs but also promote task shifting to CHWs.

- Monitoring and Evaluation (M&E)

A close monitoring and evaluation of routine SRH practices would enforce the implementation of operational standards and professional ethics and help health officers to fill the gaps in SRH service provision level. In addition, to improve quality of SRH service provision, M&E would help the health officers and managers to observe the translation of knowledge into practice post capacity building training.

- Knowledge Transfer and Exchange IEC/ BCC

Communication between HSPs and patients would also be improved dramatically by the provision of language trainings in Dari and Pashto languages and common dialects. This is especially true in Kabul, where the population encompasses many displaced people from across all ethnic groups. In addition, international guidelines and awareness toolkits should effectively be translated into both Dari and Pashtu languages, and pictorial messages should fit the Afghan social context more closely.

Sustainable HSPs' Capacity Building Training Programs continue to be required but the incentive scheme e.g. per diem payments for attendance need to be reviewed. HSPs should be incentivized to attend training based on their field of work and priorities. Currently, the quality, appropriateness and applicability of training is overshadowed by the quantity. If possible training should be provided at health facilities, so they can easily transfer knowledge into routine practices, and also health officers/trainers could easily monitor the outcome of their trainings.

The expansion of youth support centers would improve people's SRH related knowledge and reduce sensitivities because adolescents will be encouraged to call and obtain SRH information, without the shame of face-to-face contact.

Long-Term

- Psychosocial Support for GBV Sufferers

A substantial proportion of women suffer from mental health issues due to interpersonal violence but their mental illness is overlooked. The provision of psychosocial support and registration of GBV cases should be integrated into health service provision protocols. Health service providers should be trained properly to provide initial psychosocial and medical support to victims and refer them to specialist counsellors.

In addition, a significant number of people would benefit from expansion of psychosocial counselling programs in all health facilities and at the community level. Since there are shortages of psychosocial counsellors, the recruitment and training of more health staff and expansion of free of cost psychosocial counselling support to GBV survivors and patients who suffer from mental illnesses would improve women's health and well-being.

Provision of psychosocial counselling to HSPs would also create a more trustable and friendly professional working environment, and the quality of SRH services could be improved. HSPs' better mental health and well-being also facilitate more genuine communication with patients, which encourage patients' SRH service uptake.

10.2.3. Recommendations at the Individual Level

Short-term Actions

- Supplementary Food Distribution

Since many female participants were malnourished and anaemic, I believe it would be crucial to provide supplementary food to women, particularly women during pregnancy and post-childbirth. The MoPH with collaboration of Ministry of Agriculture and Afghan Family Guidance Association (AFGA) could subsidize such programs. Around forty years ago AFGA used to distribute milk, wheat and biscuits. Such supplementary food

distribution would improve the health of a large proportion of women who suffer from malnourishment due to poor living status.

- Free Distribution of Contraceptives

Promoting coherence among all implementing organisation's activities would help free and accessible Family Planning methods to women in remote areas who cannot afford contraception or might not have access to HFs. In a long run such action would reduce fertility rate, promote child spacing and promotes mother's health.

Medium-term Actions

- Vocational Training

Such training courses could empower women, especially those who got married at a young age and missed a chance to go to school, and also improve women's autonomy in decision-making, movement and self-esteem. Offering microcredits to start small businesses, or access to vocational skills boost women's self-confidence, esteem and values. This would be very useful given that a large proportion of Afghan families suffer from unemployment, and/or poverty.

In addition, economic independency could increase the honour and trust of women among their family members, because they could provide financial support to the households. To increase acceptance of women's income generation within household it would be essential to have mothers-in-law also involved in such training. For instance Health Net TPO is an organisation that works in remote vicinities. Their male and female trainers go to provinces and districts and recruit men and women who are interested in acquiring skills. Then these trained community members train other men and women in their own locality. This organisation's work could be replicated in many communities and enable men and women to learn new skills and build up a sustainable income. Since they are drawing on positives, this 'Asset Based' approach is not easily controlled by RHD, but an expanding and existing successful program may be easier than starting a new program. This intervention could be implemented successfully if multi-sectoral entities and NGOs extend their objectives in terms of women's capacity building and empowerment.

- Male and Civil Society Involvement

To address the wider issue of men's reluctance to accept contraception, and their desire for large families, it would be critical to begin integrating SRH programs into the Afghan culture. Community health promotion programs could be effective, especially with an emphasis on male SRH and increasing men's support for family planning.

Since men are heavy users of smart phones, it may be possible to turn their use to the advantage of SRH. Delivery of technology-based SRH interventions via smart phones (mHealth Service) could improve men's sexual knowledge and behaviour especially when such knowledge and behaviour change is recommended and supported by religious and tribal leaders (the accepted authority figures for the majority of men). Clever use of mHealth could begin to turn a negative into a positive and start to break down some unhelpful taboos.

Since religious leaders are closely connected with communities, and highly respected, their endorsement of increased SRH knowledge changing practices around multi-pregnancies, son-preferences, child-spacing etc. among people, service providers as well as service users would be vital. I recommend the development of high quality SRH educational programs for religious and tribal leaders and delivery of these by respected male health professionals.

- Home-based Literacy and Health Education Courses

Such courses would be very effective for those girls and women who are not allowed to leave their houses. Literacy and health education courses should also be provided for mothers-in-law and other elderly women in the household because they play a substantial role in relation to SRH and health seeking behaviours of other female members of the household. The Ministry of Public Health, through CHWs could recruit females who are educated in the locality, give them a fixed wage and provide them with teaching materials. These teachers not only earn an income but also increase literacy and health awareness among girls and women in their localities.

Long-term Action

- Mobile health (mHealth), Age-appropriate, Culturally Acceptable Comprehensive Sexuality Education (CSE)

In restricted societies sexuality education faces many challenges. As a matter of fact, the initial stage of advocating people around sexuality education might confront some resistance in short-term scale.

To tackle misconception around sexuality education, it is recommended that age-appropriate, culturally acceptable and comprehensive sexuality education, which is scientifically correct, could be available to students. Parents could be engaged in the sexuality education for instance, teachers could plan class activities and homework to encourage students to communicate about selected topics with parents more openly.

Since the personality of a person is shaped from childhood, giving honour and value to a daughter may encourage her to share her views in the household environment. It is crucial for parents to care for and value their children equally, and to allow their girls to go to school. Educated girls are more likely to support education for her children too and the link between education and health seeking behaviour and SRH service uptake is well known.

A technology-based sexual and reproductive health intervention via smart phones increases SRH awareness among men and women. Distribution of free mobile phones to each households in rural areas not only increase people awareness around SRH but also connect individuals with CHWs and local HFs. MoPH/RHD with collaboration with MoE, MICT and private telecommunication companies could design text messages with the aim to reduce maternal mortality and morbidity. Such interventions would break down of some unhelpful practices, change parents perception around SRH communication and would increases conjugal communication.

These were some aspects that I recognised and focused narrowly on the above recommendations. A summary of recommendations is demonstrated in Table 16. Some of these recommendations are not strongly evidenced from my dissertation however logically are included as they all needed to work together.

Table 16. Summary of Recommendations at the Health System, Health Provision and Individual Levels

	Interventions	Short-term Actions	Medium-term Actions	Long-term Actions
Health System Level	Review similar contexts' effective SRH interventions		<ul style="list-style-type: none"> - Inclusion of SRH in Political Agenda Replicate applicable global interventions according to the Afghan culture - Ownership of their own ideas 	
	'Framework of action' Monitoring and Evaluation (M&E) and SRH service quality assurance		<ul style="list-style-type: none"> - M&E health service practices against national health needs - Support various actors contribution - Exploring health system barriers - Identification of disparity of similar SRH projects' activities - Routine SRH practices quality assurance - Effective SRHP implementation - Improves multi-sectorial communication and coordination - Identification of implementing organisations' weakness or strength and performance outcome 	
	Enhancing Surveillance System		<ul style="list-style-type: none"> - Reporting process to HMIS - Health database management - Digitalization of health facilities' reporting systems and database management - Promote Political commitment - Help the MoPH/RHD to evaluate the health facilities' routine practices and identify the burden of SRH issues and women's health needs 	
	Professional Ethics enforcement Discipline Malpractice and Corruptions		<ul style="list-style-type: none"> - Design capacity building training programmes to enhance HSPs knowledge and accountability for medical professional behaviour, patients' rights and privacy and professional commitments - Increase quality routine SRH practices - Promotion/ demotion - Transparency in employees' contract details - Reduce paperwork to increase HSPs contact with patients 	
	Civil registration system and Electronic National Identity		<ul style="list-style-type: none"> - Home based or institutional childbirth registration - This action would help the Central Statistics Office (CSO) to obtain factual statistics instead of estimating birth and death ratios. If the MoPH in collaboration of Ministry of Justice (MoJ), Ministry of Hajj and Religious Affairs (MoHRA) and Ministry of Communication & Information Technology (MCIT) enforced the distribution of electronic national identity and registration of marriage 	<ul style="list-style-type: none"> - Improve records of births and deaths, marriages - Decrease the level of young age marriage, home-based childbirth and high-fertility rate. - Improve measurements of life expectancy and delay young age marriage.
	Sustainability of SRH Projects and International Funds		<ul style="list-style-type: none"> - The MoPH in collaboration with international donors could also plan for capacity building with national HSPs 	<ul style="list-style-type: none"> - Sustained political commitment, inclusion of all SRH needs in the political agenda - Proper financial and management planning - Multi-sectorial commitment would improve a broad and

				equal access to SRH services
	Behavioural Change and Communication/ Information Education and Communication IEC/ BCC and use of Mass Media		<ul style="list-style-type: none"> - Design socially acceptable SRH advocacy programmes - Provide SRH messages through use billboards - Produce and distribute a variety of SRH advocacy materials (picture messages/ posters) to educate a largely non-or semi-literate population to promote SRH service uptake 	<ul style="list-style-type: none"> - Increase SRH awareness - Promote multi-sectorial coordination and communication - Change socio-cultural beliefs and detrimental practices - - Produce radio and video spots and dramas in both Dari and Pashto languages to educate people on healthy practices and promote Health seeking behaviour change. - Decrease sensitivities about SRH issues and boosts confidence to properly communication SRH issues
	Psychosocial Support		<ul style="list-style-type: none"> - Recruitment of resources to support GBV cases - Increase psychosocial counselling at all HFs - Support for GBV survivors and women's mental illness 	<ul style="list-style-type: none"> - Elimination of Interpersonal violence - Support the integration of mental health and psychosocial counselling services into the public health system of Afghanistan
	Comprehensive Sexuality Education & Mobile health (m health)		<ul style="list-style-type: none"> - Improve multi-sectorial coordination - Use of Mobile phones to increase people's awareness - Encourage private sector's contribution - Technology-based sexual and reproductive health interventions via smart phones 	<ul style="list-style-type: none"> - MoPH/ RHD can design effective and socially acceptable Sexuality Education programmes with collaboration of Ministry of Communication & Information Technology (MCIT) and MoE - Improve SRH seeking behaviour
	Knowledge exchange & Transfer Telemedicine technology system for insecure and unstable locations			<ul style="list-style-type: none"> - Develop cost-effective capacity building programmes - Interdepartmental SRH awareness - Increase the level of social awareness through various channels - Reduce concerns over reduction of external aids - Increase SRH awareness. Commitments to connect national health facilities to the main hospitals and international health institutions; in order to improve quality health services
	Sexuality education to those adolescents who have access to schools			<ul style="list-style-type: none"> - Plan and design effective sexuality education school programmes with collaboration of MoE and MoHE and some implementing - Change socio-cultural beliefs and detrimental practices - Inclusion of reproductive health curriculum in the schools subjects

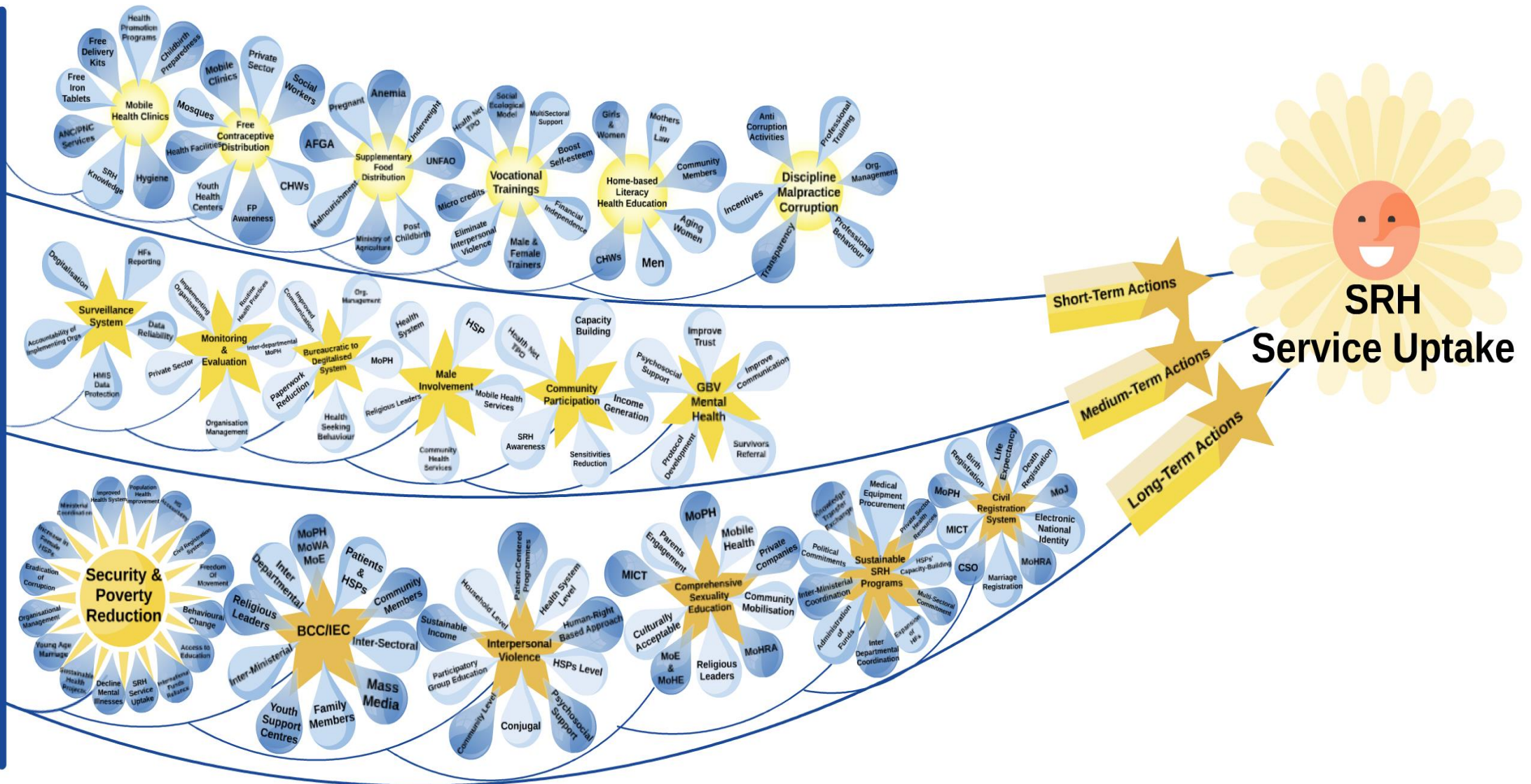
Health Provision Level	Interventions	Short-term Actions	Medium-term Actions	Long-term Actions
	Mobile Clinic Activities	<ul style="list-style-type: none"> - Increase access to SRH services - Increase SRH awareness through male and female health educators - Reduce overcrowding in HFs - 	<ul style="list-style-type: none"> - Increase in SRH service uptake 	<ul style="list-style-type: none"> - Increase in SRH service uptake
	Monitoring and Evaluation (M&E)		<ul style="list-style-type: none"> - Routine practices - To observe the translation of knowledge into practice post capacity building training. 	<ul style="list-style-type: none"> - Increase quality of health service provision
	Absorption of Resources from private institutions		<ul style="list-style-type: none"> - Increase in number of health educators - Financial support 	<ul style="list-style-type: none"> - Job creation at the community level - Task shifting to CHWs
	Professional Communication		<ul style="list-style-type: none"> - Plan and design training programmes to improve HSPs professional communication skills - Provided technical and linguistic training to HSPs 	<ul style="list-style-type: none"> - Reduces language barriers and misunderstandings between HSPs and patients through professional communication training in two local languages - Create trustable environment
	Professional Ethics Enforcement		<ul style="list-style-type: none"> - Increase proper routine SRH practices - Emphasis on considering patients' rights, privacy and values 	<ul style="list-style-type: none"> - Reduction of judgmental and abusive behaviour amongst HSPs - Increase trust and honour between HSPs and patients
	Switching from a Bureaucratic Health Service Provision to Digitalized System		<ul style="list-style-type: none"> - Proper reporting process to HMIS - More time for patients - Increase proper surveillance system - Robust organisational work and health service provision planning 	<ul style="list-style-type: none"> - Digitalising health facilities' reporting system - Reduce multiple forms and integrate patient's record in one file - Improve communication and knowledge transfer - Improve HSPs' face-to-face communication with patients
	Psychosocial Support for GBV sufferers		<ul style="list-style-type: none"> - Increase psychosocial counselling at all HF levels - Improve patient's referral system 	<ul style="list-style-type: none"> - Support for GBV survivors and women's mental illnesses - Provide psychosocial support to HSPs
	Male Involvement		<ul style="list-style-type: none"> - Recruitment of male HSPs - Training of male HSPs for ANC, FP and mental illness counselling - Task shifting among HSPs 	<ul style="list-style-type: none"> - Encourage men to accompany their wives and take part in ANC and FP counselling and decision making - Reduce sensitivities - Increase SRH service uptake
	Knowledge Transfer and Exchange IEC/ BCC		<ul style="list-style-type: none"> - Effective in-service trainings - Increase SRH awareness - Capacity building 	<ul style="list-style-type: none"> - SRH knowledge improvement - Changing socio-cultural beliefs and detrimental practices - Knowledge exchange decreases sensitivities about SRH issues and stigma - Improve positive attitude of HSPs towards patients
Discipline Malpractice and Corruptions		<ul style="list-style-type: none"> - A strong organisational management, enforcement of professional standards and disciplining of malpractice and corruption - Transparency in employees' contract details, a 		

			gesture of appreciation and some incentives to avoid corruption	
	Task Shifting and Community Health Workers (CHWs) Participation		<ul style="list-style-type: none"> - Expand the role of Community Health Workers (CHWs) - Provide delivery kits to mothers-in-law and training them about childbirth preparedness and quick decision-making in terms of pregnancy or childbirth complications - Lessons can be learnt from one of the NGOs (Health Net TPO) 	

Individual Level	Interventions	Short-term Actions	Medium-term Actions	Long-term Actions
	Free Contraceptive Distribution	<ul style="list-style-type: none"> - Helps women in remote area who cannot afford contraception or might not have access to HFs - Reduces fertility rate 		
	Involvement of Men and Civil Society	<ul style="list-style-type: none"> - Religious leaders role is crucial in terms of SRH awareness - Encourage community participation 		<ul style="list-style-type: none"> - Improve communication - Reduce SRH sensitivities - Increase women's honour at the household level - Delay young age marriage
	Supplementary Food Distribution during pregnancy and post-childbirth	<ul style="list-style-type: none"> - Poor t women particularly in rural areas can benefit from supplementary food consumption - Improve the health status of women who suffer from malnourishment and anaemia - Encourages breast feeding 		<ul style="list-style-type: none"> - Improve health and well-being of women - Reduce SRH complications
	Financial Empowerment Through Vocational Trainings	<ul style="list-style-type: none"> - Income generation - Financial independence - Women's financial support to husband 		<ul style="list-style-type: none"> - Reduction of dishonour and violence - Increase in power of decision making - Increase value to women's opinion - Reduction of household clashes while all women are busy in vocational trainings - Reduces Poverty and financial dependence
	Mobile health (m health) Age-appropriate, Culturally Acceptable Comprehensive Sexuality Education (CSE)		<ul style="list-style-type: none"> -Distribution of free mobile phones to each household in rural areas -Technology-based sexual and reproductive health interventions via smart phones increases SRH awareness among men and women -Connect individuals with CHWs and local HFs 	<ul style="list-style-type: none"> - Saves lives - Break down of some unhelpful practices - Change parents perception around SRH communication - Increases conjugal communication - Changes SRH seeking behaviour - Promote public and private health sector partnerships and mobile network operators -Text messages could aim to reduce maternal mortality and morbidity

	Home-based Literacy and Age-appropriate, Culturally Acceptable Comprehensive Sexuality Education (CSE) Courses		<ul style="list-style-type: none"> - MoPH, through CHWs could recruit educated females in the locality, give them a fixed wage and provide them with teaching materials - Effective for those girls and women who are not allowed to leave their houses - Literacy and health education courses should also be provided for mothers-in-law and other elderly women in the household 	<ul style="list-style-type: none"> -Increase SRH awareness for those adolescents who have access to education
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Since many recommendations are interlinked at individual, health service provision and health system levels, it is challenging to segregate recommendations in terms of time-scales and actors' level. In other words, this is another layer of complexity in terms of short, medium and long-term actions. For instance, all short, medium and long-term actions are connected with security and poverty reduction. Some interventions are challenging to be implemented by MoPH individually. There is need for multi-sectoral coordination and commitments. In addition, many actions that impact on individuals SRH service uptake can be planned and organised at the health system level and can be implemented by health service providers or other implementing bodies who are supported by international funders. Thus, Figure 16 demonstrates interlinks between short, medium and long-term actions in order to improve SRH uptake.



Chapter Eleven

11.1. Conclusion:

Sexual and reproductive health policy has only been given attention globally over the last 24 years as an important means of improving health outcomes, particularly in low- and middle-income countries. However countries such as Afghanistan have a relatively low level of SRH services uptake. This is a major reason for the high level of maternal mortality and morbidity, sexually transmitted infections (STIs), unintended and multi-pregnancies and gender based violence.

This research focused on women's health and wellbeing through their life-cycle, because reproductive health extends far beyond the 9 months of pregnancy and 3 months of post-partum. In Afghan society, many women suffer from birth to death. However the life long impact of social factors on women's SRH is not measured in a RH Policy. The research findings show the key factors underlying the poor SRH of Afghan women are the absence of knowledge about SRH, poor communication, and a lack of honour and trust both between individuals and within the health system. These factors play in various ways to limit both SRH service provision and uptake.

The key findings add to the body of knowledge by providing detailed descriptions and analysis of how the themes impact at the health system level, HSP level and individual women's experiences. The findings also illuminate how dependence on international NGOs for policy design, implementation, service planning and provision in advertently undermines cohesion within MoPH and health facilities.

Due to the lack of trust and communication amongst MoPH departments, Ministries and implementing organisations, survey results, interventions and monitoring reports are not consistently or accurately compiled, disseminated and incorporated into the reform process of the National Reproductive Health Policy (NRHP). The resulting multiplicity of statistical data for standard health outcomes, such as the actual ratio of maternal death and vulnerability, Total Fertility rate, and ANC/ PNC visits etc. causes confusion in terms of understanding the actual performances of the health system in terms of the health outcomes.

One of the reasons for the lack of communication and trust amongst MoPH departments is the multiplicity and disparity of funding by various donors. Hence, particular departments within the MoPH are more liable to report back to their funders than to the MoPH senior officers. International organisations' funding systems have become a major concern because, on the one hand, it improves the total resources of SRH health system and increases people's access, but on the other hand, it also fragments the health system, creates tension and increases dependence on international funds at all levels of the health system.

Of greater impact upon the operations of the health system is how Afghan culture affects MoPH officials and health service providers, as well as the women using the services. In fact it is difficult to separate culture from professional practices and health services. Policy staff and HSPs both experience and reproduce the culture around them, even when dealing with known problems and limitations. For instance, both socially and within official policy Afghan men are excluded from any consideration of the SRH of women. The low priority on male involvement is partly to do with the way global SRH policies have developed over the past 24 years and partly the result of the particular cultural values and structures of power within Afghan society.

It is essential to note that associated health issues of importance for maternal (and child health) are missing from the policy. Important omissions include the identification and treatment of both mental health and addiction. Due to social stigma issues and addictions in women remain hidden. Therefore no guidelines or protocols have been developed to identify and treat women with addiction and provide psychosocial support at the community and health provision levels. Similar stigma surrounds mental health issues. This is critical for health service improvement, as some of the negative behaviours amongst HSPs, such as violence and disrespect towards patients/service users, imposition of personal beliefs by midwives and doctors upon women seeking SRH support, misunderstanding, false beliefs, unprofessional behaviour in terms of incomplete examinations, records and treatment, misappropriation of resources etc, may be at least partially explained by the anecdotally high rates of mental illness amongst HSPs.

The inappropriateness and ineffectiveness of much of the training being delivered to HSPs and the lack of implementation, evaluation and follow-up of the training is another part of the jigsaw particularly around GBV training. Although much of the violence towards patients is practiced by HSPs, the GBV is perceived as a 'Western

concept', perpetuated by men. Therefore, HSPs do not practice psychosocial support as part of their routine practices and there are almost no services to refer patients to, even if HSPs wanted to. In addition, training material did not convey useful messages because diagrams and pictures did not convey socially appropriate and correct translations from English to local languages.

Linguistic barriers between HSPs and patients at the health provision level also hinder HSPs communication with patients and understanding of their health issues and exacerbate the chain of communication and trust gaps between HSPs, patients and senior staff.

At the household and individual levels, this study also underlines the negative impact of social practices around marriage on women's decision-making power to seek health services and exacerbation of interpersonal violence. Contrary to what was perceived before starting this research, not all violence is GBV. Women often conduct violence against another woman or instigate the torture or harass of another female member of the household by a male members of the family.

The specific roles of the mother-in-law and other women in the household in relation to health and health seeking behaviours of other female members of the household are discussed in a level of detail not provided elsewhere. However it becomes apparent that the SRH needs of aging women, particularly the menopause, are completely excluded from the formal policies and seem to be rarely discussed in any social and political spaces, including households.

As a matter of the fact, this research underlined three types of knowledge (religious beliefs, biomedical and folk) that impact on SRH service uptake. It is noted that women tend to use home remedies and refer to the advice of religious leaders and edicts before accessing of biomedical health services.

Although, I did not want to focus around 'deficit-based' approaches, in practice there are so many gaps in the RH system that I ended up applying a lot of 'deficit-based' approach thinking. It was difficult to find positive examples to use where 'Asset – based' approaches might apply although Health Net TPO provides good example (See 5.2. and 10.2.1 Sections). Even in this situation where there are many challenges, this organisation demonstrates how an 'Asset-based' approach can be applied in the Afghan context.

In summary, the application of a 'Broader framework of thinking' provided a distinctive understanding of the processes of policy reform and implementation by various actors over both short and long time scales. This framework assisted with a better understanding of the significance of men's involvement, not only in terms of SRH service uptake but also in the policy reform process and implementation.

Poor rates of SRH service uptake have a long-term impact and will have major impacts on family welfare and future generations because of the high ratio of maternal death and disability among women during their childbearing age. Exploring the social factors and understanding the policy gaps in the complex SRH sector aided identification of applicable interventions in conflict-affected Afghan settings in order to decline maternal mortality and morbidity ratio, which is a key sustainable development Goals (SDGs).

11.2. Research Strength

As part of the research, I arranged FGDs, with high-ranking health professionals, donors and implementing organisations, which proved to be the first steps in a process of bridging coordination gaps and bringing various stakeholders together. Thus, the research became part of the SRH improvement process, and the outcome of my research goals. In other words, it contributed in the beginning to changes by gathering all the actors at the reproductive health system level who previously had almost never met and they had a chance to communicate shared knowledge around achievements and failures in the reproductive health sector.

The 'Broader framework of thinking' enabled me identify key players, develop networks and build trust amongst a number of actors in MoPH and some implementing organisations who then began evaluating their roles in terms of policy reform and implementation.

Although this research was conducted in four health facilities, in two districts of Kabul, understanding the perceptions of participants recruited from 23 provinces and 74 districts and sub-districts of Afghanistan allowed me to comprehend the breadth and depth of their health needs and their problems accessing and obtaining SRH services in both their original place of residence and in the health facilities of my research. It

may be that some of the struggles and challenges found by both HSPs and SRH service users, particularly around language barriers, were relatively unique to Kabul due to the range and number of displaced people now reside in Kabul districts.

11.2.1. Immediate Benefit of This Research

Conducting interviews with women in health facilities and their households meant that I sometimes felt the need to show empathy, emotional support and counselling based on personal life experiences. In spite of all cultural beliefs, I encouraged women to build a communication link with their husbands and understand their opinions. Listening to participants' untold stories for as long as they wanted to talk brought them some relief and peace of mind (psychological support).

Occasionally, I facilitated and helped patients to obtain health services, particularly those who did not bring their visiting cards. For instance, some patients wanted to obtain contraceptives. However with their low Hg level (between 7-9hg/dL) they should have also been given Ferfolic tablets. After seeing their records, I negotiated with the HSPs to see if they could visit the patient again and provide some additional vital health services.

I also responded to some HSPs' queries, during their lunchtime, answering queries about health concerns when they did not have the courage to ask their seniors. I also tried to reduce the communication gap between HSPs and patients, HSPs and health officers by encouraging them to have effective dialogue.

11.2.2. Long-Term Benefit of This Research:

- Implementation of the recommended applicable interventions would improve sexual and reproductive health service uptake. It would also encourage behavioural change at an individual level amongst patients, family members, HSPs and decision-makers.
- Reduction of sensitivities in terms of SRH related issues, communication and knowledge exchange and improvement of SRH service uptake through the application of smart phones and social media.

- Inclusion of SRH as human-rights in the political agenda, and strengthening the inter-ministerial and multi-organisational commitments. In addition, men's involvement in SRH policy processes, health service provision and service uptake

11.3. Research Limitations

The contextual challenge that affected my research original goal was the selection of four health facilities (district hospitals and comprehensive health clinics) by the MoPH/Kabul Health Administration Office, due to insecurity, associated limitation of movement and safety concerns rather than homes or community settings, which was initially planned. Despite this, I was still given access to some participants' homes and gained much understanding of their day-to-day lives in relations to SRH.

Although, this research achieved its aims there were occasions when insecurity hindered my movements or delayed my access to study locations. For instance, I witnessed attack incidents twice while travelling from one health facility to another. As mentioned previously, I used to go to the CHCs in the morning because they work from 8:00 a.m. to 12:00 p.m. After finishing my routine fieldwork in CHCs, I used to go to the DHs in the afternoons using local buses. There was an incident of a suicide attack on the Pul e Charkhi road that was my main route for reaching the ASB/DH. I approached the scene of a suicide attack that had happened half an hour before my arrival on 'Dehmazang Road' (this square connects the centre of Kabul to the western districts of Kabul). However, it is difficult to avoid such unforeseen incidents. My research assistant accompanied me during the periods of most concern (travel, interviews and discussion especially with male participants e.g. religious leaders and husbands). These types of situations however highlighted the constraints many of my participants faced in accessing services, especially if their households were unwilling to support their use of biomedical services.

The general instability did not affect my research. Overall the insecurity has had couple of effects:

Initially, the overall design of my project was affected because initially, I wanted to conduct an ethnographic study by observing one of the tribes in a rural area (Hussain

Khail). However when I got to Kabul, the insecurity was a reason for not being able to spend time with the tribe.

A limitation in applying the 'Broader Thinking framework' was in gaining access to and obtaining the perspectives of organisations that had an effective role in the formulation of RH Policy. Since RH Policy was already adapted I did not directly observe the policy formulation and reformation process. Therefore, my research relied on analysis of RH Policy and Strategy obtained from MoPH along with interview and FGDs data.

Apart from data collection, the most significant challenge I faced was the immense volume of data, which meant the transcription, analysis and interpretation was extremely time consuming. Since research participants talked in two national languages (Dari and Pashto) with various dialects, I sometime had problem understanding their ideas. It was time consuming listening and listening to tapes to understand, transcribe and translate the data.

As an insider one of the limitations of this research at times was cultural blindness because there were many instances that seemed to be normal to me. But from a 'Western' perspective they were shocking. Discussing my data with my supervisors helped me to deal with this, for instance, observing women using some home remedies (use of sheep dung in their intimate part etc.) or observing various types of violence. On the other hand, not being able to draw on my professional training was also difficult. I felt powerless when I could not do anything to help an ill woman or when observing mal-practice in health facilities.

My study has little content related to menopause. Menopause was less of a concern because a large proportion of women die before reaching menopause. Perhaps, I should have asked more about the menopause but actually my primary concern was women who were in their fertile years. Maybe I would have been able to follow through my original research plan, which was to talk to women in their houses privately. I would have seen a greater spread of women of all ages.

Because I was restricted to primarily seeking participants from amongst Out Patients in health facilities, the majority of women coming there were not old enough to be in menopause. They were there because they were having problems with pregnancies and childbirth, or were accompanying a daughter or daughter-in-law.

Since health issues are complex, the issue of mental illness and women's addiction are both prevalent and intertwined. Throughout SRH issues, I struggled to contain the topic to a manageable level or tight focus. In addition, issues related to men's SRH were not the focus of this research.

If I had my research time all over again, I would have explored the consequences of poverty, malnourishment and interpersonal violence on pregnant women's health, and also mental health issues during women's life cycles. Moreover I would have examined the negative and positive impact of lay practices and consumption of un-prescribed medicine through women's reproductive life cycle in details and in-depth.

Although it was easy to identify social factors, because of the number of recruited participants and the consistency of my research themes, I would want to share my research findings with a social policy theorist or social anthropologist to make a social design and identify how the social dynamics would help improvement of SRH uptake.

11.4. Recommended Future Research

This research is a rudimentary effort to identify and began to address the SRH service uptake gaps. However more research needs to be carried out to overcome the research limitations and identify the issues around:

1. The impact of socio-cultural issues on men's sexual and reproductive health and well-being.
2. The impact of mental illness on women during pregnancy and post childbirth.
3. The causes and social consequences of women's addiction.
4. The influence of poverty, interpersonal violence and malnutrition on women and child during pregnancy.
5. The impact of un-prescribed medicines intake on pregnant women and child's health.
6. The impact of sexual violence on the health and well-being of both men and women.
7. The impact of political-economy factors on women's health and well-being.

11.5. Personal Lessons and Achievements

This research improved my intellectual and personal abilities and helped me develop self-discipline and an effective work and life balance. I participated in many conferences and academic competitions and won many prizes including:

- The best research presentation during the annual research review at School of Medicine, Pharmacy and Health.
- The best Poster presentation in the Wolfson Research Institute for Health and Wellbeing Colloquium.
- The best qualitative health research presentation in the Qualitative Health Research Writing Group Network Symposium.
- The best audience choice for my presentation in the 3-minute thesis competition in Durham University.

I understand that winning a prize is not an easy task. However my PhD research data and diligence from my supervisor increased my self-confidence and it was a great opportunity to aspire to academic excellence.

Lastly, doing this research has equipped me with the skills and expertise to ensure that I can bring about a positive change in women's health. On completing the PhD, I hope to conduct high-quality, policy-driven research and/or policy reform and implementation projects. Ideally I hope to work closely with the governmental and non-governmental agencies responsible for healthcare provision in Afghanistan, in order to realize my dream to improve the lives of women in Afghanistan, for which there is so much need.

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Appendices

Appendix A1 : Topic Guide:

1. Welcome and thank participant for taking part in the research. 5 minutes
2. Self introduction
 - a. Researcher / Moderator
3. Points to discuss with participants prior to the signing Consent Form 10 minutes
 - a. Explain the Participant Information Sheet:
 - i. Project aims and objectives
 - ii. The aim of inviting participant(s) for the interview / observation
 - iii. Duration of interview/ observation
4. Signing Consent Form
 - a. Explain why using a written agreement
 - b. Read through the consent form with participant to:
 - i. Understand the statement
 - ii. Agree with it
 - iii. Have the opportunity to ask questions
 - iv. Seeking participant(s)' consent for recording the interview / discussion
5. Participant(s) introduction 2 minutes

Begin (Semi-structured) interview (guide only)

Proposed Questions from pregnant women:

1. Tell me about your home life and family
2. How do you share household tasks in your home?
3. Tell me about your pregnancy.
4. What does the rest of the family think about your pregnancy? How do they show it?
5. How do you plan to look after your health and the baby's health throughout your pregnancy and delivery?
6. What are the most important factors in choosing how to look after yourself and your baby?
7. How do/did you deal with Health providers and Traditional Birth Attendants and why?
8. If you could make any changes to how you care for yourself and your baby what would you change and why?

Proposed Questions from the health providers:

1. What services are obtained/ provided to women at the health facility?
2. What are the challenges that you might face during the provision of routine and emergency services?
3. How did you choose the best ways to influence people to talk about sexual behaviour?
4. What are the best ways to influence people taking part in supporting women's health needs?
5. What changes do you think pregnant women would like to see if you had the freedom and resources to change the way the clinical/hospital/care centre functions?
6. What changes would you make if you had the freedom and resources to change the way the clinical/hospital/care centre functions? Why?

Closing Interview:

- Are you feeling okay about what we have discussed?
- You can contact me at any time to discuss what we have discussed today or if you have any questions about the research.
- Thanks for your participation.

A 2. Participant Information Sheet and Consent Form

Participant Information Sheet for Pregnant Women

I am Manizha Hadi. I am a medical school graduate. I want to explore Afghan people's experiences of using maternal health care and any difficulties they might face.

I am going to give you some information and invite you to be part of this research. Before you decide whether or not you will participate in the research you can talk to anyone you feel comfortable with about the research. This consent form may contain words that you do not understand. Please feel free to ask me and I will take the time to explain.

The purpose of the research (Note to ethics committee - If the participant has a low level of literacy, the below information will be explained verbally)

This research attempts to identify culturally-appropriate health development approaches to increase the level of utilisation and quality provision of maternal health care. Exploring various ethnic groups' perspectives in Afghan society could also help to begin timely interventions to decrease the level of maternal mortality and morbidity.

Participant Selection and Voluntary Participation

You are being invited to take part in this research because of you are pregnant or have recently delivered a child. Your experiences of care before, during and after childbirth can contribute much to our understanding and knowledge of local health beliefs and practices around motherhood and maternal health. Your participation in this research is entirely voluntary. If you change your mind later you can stop participating, even if you agreed earlier.

Procedures

I am inviting you to take part in this research project. I am asking you to help us learn more about the Afghan people's experiences of maternal health issues. I want to learn more about your life, your pregnancy and your opinion on any difficulties you might face during pregnancy, childbirth and after childbirth.

To understand this I would like to be able to meet with you and observe your daily life over the time of your pregnancy. To do this I would like to visit you at home occasionally during your pregnancy*. How often I visit you and how long I stay in your home each visit will be agreed with you before each visit. I will also ask you for a formal interview towards the end of my study to clarify any remaining questions I have. The interview will take no more than 90 minutes of your time.

I would like to take notes about your pregnancy and life with your permission. I would also like to record the interview. The notes and the recording are to

ensure that I am accurate in understanding what you tell me. I will only take notes and record with your permission.

Any information recorded is anonymous and confidential, no quotes or other results arising from your participation in this study will be included in any reports, even anonymously, without your agreement. No one else will access the information documented during your participation.

*NOTE to ethics committee - An alternative wording may be 'or over the time of my study' depending on when the participant is recruited and her individual circumstances.

Permission to Participate in the Study

Participant Name (if applicable): _____

Interview Location: _____

Name of Researcher: _____

I have read the foregoing information. I understand I have been invited to participate in observations of daily life and an interview about the cultural, institutional and structural barriers to routine and emergency maternal health care utilisation and provision in Afghanistan which result in higher maternal mortality and morbidity ratio. I will participate in **a)** observations of my daily life **b)** a one-to-one interview **c)** both of these (delete any if needed).

I have been informed that the risks are minimal. I have been advised the number, dates and duration of observations will be agreed in advance with me by the researcher. The interview will be conducted in a neutral territory to ensure personal safety. If I do not wish to answer any of the questions during the interview, I may say so and researcher will move on to the next question. I am aware that there may be no benefit to me personally.

I have had the opportunity to ask questions about the research and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the interview at any time without having to give a reason. I also consent to the researcher recording the interview.

I do / do not agree to quotes or other results arising from my participation in the study being included, even anonymously in any reports about the study.

Signature of participant _____

Date _____

Day/month/year

Participant Information Sheet and Consent Form (Dari Version)

رضایت نامه و اطلاعات ضروری

حقوق زیر حق اشخاصی است که در مصاحبه و یا بحث اکادمیک حصه میگیرند.

تاریخ _____

اسم مصاحبه کننده: _____

محل انجام مصاحبه: _____

عنوان موضوع:

جنسیت، صحت و حقوق مدنی: بررسی حقوق و صلاحیت زنان و عوامل اجتماعی، فرهنگی و مذهبی در دریافت تسهیلات صحتی باروری و فراهم آوری خدمات صحتی باروری در افغانستان

*. تصدیق مینمایم موضوعاتی را که در مورد تحقیق متذکره به تاریخ _____ خواندم قابل قبول ام بوده، هر گونه سوال را چه قبل از شروع مصاحبه و چه حین مراحل تحقیق علمی بپرسم.

*. اشتراک در این مصاحبه داوطلبانه بوده و هر زمانی میتوانم بدون از دست دادن امتیازات قانونی و داشتن کدام دلیل از انجام مصاحبه منصرف شوم.

*. ممکن بخشی از معلومات بدست آمده توسط سرپرست و یا مسوؤل این تحقیق علمی در دانشگاه با در نظر داشت ایجابات وظیفوی بررسی گردد، تتبع هر یکی از محققین را در موارد ارایه شده مجوز میدانم.

*. برای اشتراک درین تحقیق موافقت دارم.

*. مسوؤلیت هر خطری که به من عاید گردد به دوش محقق خواهد بود.

*. یک کپی از ورق امضاً شده رضایت نامه را دریافت مینمایم.

به منظور ترجمه بهتر از گفته های مصاحبه شونده در صورت رضایت در جریان مصاحبه آواز ثبت و یا ریکار خواهد شد.

امضاً _____ تاریخ _____

Participant Information Sheet and Consent Form (Pashto Version)

برخه لیک او رضایت پاڼه

لاندې شرایط په هغو کسانو لپاره اړه لری چی په علمی څیړنه کی ونډه اخلی .

نیته _____

د مصاحبه کونکی نوم : _____

د مصاحبی پته : _____

د موضوع سرلیک :

جنسیت، روغتیا او مدنی حقوق: د ښځو د حقوق او صلاحیتونو ، اود افغانستان د ټولنیز، کلتوری او مذهبی لاملونو څارل چی د ښځی په روغتیا او زیږیدنو آسانتیاووی دلاس ته راوړنی اوسنډالولو کی اغیزه لری.

*. زه د دغه څیړنی موضوع چی په — نیته چی می لوستلی تائیدووم. اود هر ډول پوښتنه د مرکی له مخکی او د مرکی تر منځ کی پوښتلی شوم.

*. په دغه مرکه کی زما برخه اخیستل زما په خوښه ده. او هر کله چی وغواړم ، پی له کوم دلیل، دغه مرکه پرېښودلی شم.

*. ښایي د مرکی نه وروسته ځینی معلوماتی برخی د علمی څیړونکی له خوا د هغی په علمی څیړنه کی استعمال شی ، زه دا څیړنه مشروع بولم .

*. زه په دی مرکه کی د برخه اخیستولو لپاره چمتو یم.

*. د مرکی په وخت کی د کوم خطریا تاوان پېښی ذمه واری د څیړونکی په غاړه ده.

*. ددی برخه لیک د لاسلیک شویو یو نقل اخلم.

د ښومرکی په مقصد او د برخوالو په رضایت، د دوی غږ د مرکی په بهیر کی ثبت کیږی.

نیته _____

لاسلیک _____

Appendix B. Indexing File of Participants' Data

Indexing file V2.xlsx

Search in Sheet

Home Layout Tables Charts SmartArt Formulas Data Review

Font: Arial, 12, Bold, Italic, Underline, Text Color, Background Color

Alignment: Left, Center, Right, Top, Bottom, Wrap Text, Merge

Number: General, Percentage, Currency, Accounting, Date, Time, Text, Fraction, Decimals

Format: Normal, Bad

Cells: Insert, Delete, Format

Themes: Themes, Aa

AFB Feels shy

Major themes																					
Violence during pregnancy/childbirth post childbirth	Form of Violence	Spouse communication/ negotiation	Multi wives	wife / daughter in law as servant	No complains	New Technology	Lack of Support	God's Will	Heavy work or tiring during pregnancy	work post childbirth	Sex preferences	Economical status	Malnourished	Political Impact	Knowledge of Vaccination	Knowledge of Contraceptive	Misconception around Contraceptives	Sexual Health knowledge	HPV FP counselling	Other health issues	Medicine/ doct prescrip direct
		Social customs and shyness				No						Poor		Migrated from Khost due to lack of job opportunities		Yes but misunderstood	Condom use cause irritation and itching Depo shot causes dizziness and weaken eye sight Tablets lead to bulging tummy and weight gain	No	No information is provided regarding contraception		
		Lack of husband's support on contraception, social norms and living environment impact on women's behaviour and force them to be shy and isolated.			lack of her husband attention	No	Family									Yes. Can not negotiate condom use with husband			No.		
lifetime		Lack of husband's attention due to the second wife	yes	yes			family		all house chores	Yes	yes	poor	Yes	her husband works in Army in a province so he married another woman		Yes but not allowed. No child space	causes infertility	No		Anaemic Pale Weak	
Pregnancy Post Childbirth	Verbal Sexual	Husband never value the demand of wife. She can't negotiate condom use	no	Yes	Feel shy and never wants to low her dignity and destroy her personality		Family		All house chores	Yes		poor		no access to school	Yes	Yes but not allowed	sinful	No, never know what is arousal	No		
Pregnancy Post Childbirth	Verbal Physical	Fear from in laws and second wife of husband has broken their relationships	Yes	Yes. She is married on BAD so she suffers	No self reliance Fear from in laws and husband		Family	Yes	All house chores	Yes	She prefers	poor	Yes	Tribal fighting		Yes but not allowed to go out		No.	No	Anaemic Body Pain infected D/S area	
			No	Yes				Yes			She prefers	Poor		no access to school							
		Shy	no				family	God's will often linked to reproduction			in laws pressure	poor				no	Yes but not allowed	tub-tigation is a sin	no		High BP
not mentioned			no	yes		No		God Hides us deliver babies without any problems, never interfere in God's will	Serves 40 people at home	3rd day	In laws	poor, can't afford having good and healthy food. Only drinks tea with a piece of bread.	Yes	War, no schools in Paktiya, Displacement to Kabul. No work opportunities for her husband	No. She believes vaccination is for childbirth space	No knowledge. Husband and mother in law are against contraceptives	It is sin			Anaemic, Weak and Stomach-ache	

participants interviews HPs & Pts & F.members Obs Coordinating org staff Gov staff interviews FGD Hps interviews GBV & inequality cases Total Summary +

Appendix C. Sub-Themes and High Level Themes

Summary of Factors to Sexual & Reproductive Health Care Uptake and Provision									
No.	IC System	WPH/PHC	Widow	Household	Mother of twins	Other Family Members & Issues	Religious Leaders	Socio-cultural beliefs/ traditions	
	No enforcement of policy into	Not well supported	Young age marriage / Arranged	Sexual assault	Decision maker	Father force her daughter for marriage	Agreed PP methods		
1	No health needs assessment, meeting health is	Engagement behaviour	Multi pregnancy / very often partners and high fertility rate	Infant / Physical violence	Agreed method	Father obtains money / bride's wealth	Young age marriage is useful	Beliefs: Twins, stills are the order of a newly married girl or source of	
2	No risk factor action in the	Forgetting and abuse	Some adolescent / teen pregnancies	Infant / sexual violence	Daughter in law to provide the	Father force / abuse / his daughter to go to	Any form of sexual activity with	Agreed PP methods /	
3	Sexual health assessment conducted PP in the public	Being patients	Agreed method / no one change their existing sexual habits	Decision maker	Interfering in son and his wife / his sexual activities and / health related	Father and father in law are decision makers	Religious leaders demand for chastity in order to prevent	Agreed PP methods /	Support
4	No engagement focus on baby health sector	After her mental illness	Married women	Agreement	Sex preferences	No family behaviour of parents to children, Mother or father never discuss matters related to sexuality, puberty and changes in their son/ girl's genital region	When a woman has to submit other than be treated by a man. Other areas even if he is a doctor and said how often it is no work		Marital Issues
5	No mentions around Engagements in Public. Not performed other forms of contraceptives / condoms	Not allowed to go to PHC provision	Not allowed to go to PHC	watching pain issues	Agreed PP	Communication gap between daughter in law, husband and other family in law	Phrasing is in Hindi of /		Sexual health
6	No WPH following law enforcement	Not on terms patients back health	Marital / don't know their age	Marital	Contraceptives make a woman shy, inhibited, lead to poor eye sight	Joint family and lack of decision making power	Age of marriage, education and woman's rights are the contributory ideas that religious		Family Planning
7	No teen-mission coordination	Communication & understanding gap between mothers and decision	Marital being condition	Husband	Some mothers for parents and children's decision	Widow do not like to go to the courts	According to Islamic laws men and women have equal rights however woman's rights is not		AWG/ PHC
8	No work coordination amongst WDG and	Language barrier	Marital work during pregnancy	Sex preferences	Mother in law and daughter in law's pregnancy competition	Wife's wealth for securing a woman's future or son for WDG	Woman should know about their women's rights		Lack of trust
9	No WDG	Not PP counselling	Have poor past children	Agreed PP	Mother for son to abuse her daughter in law	Not in preferred but daughter is source of money	Husband should not hit woman		Violence
10	No meetings outcome follow-up	Ignoring (AWG, PHC and PHC) supporting provision, No PHC, weight should, the physical aspect (past children) other	No action	Condoms cause skin rashes, hair pain	Both parents and their parent has to take to ensure law is not violated PHC		Working in Public, Top income and decision of parent		Communication & understanding Bar
11	No clear bond	WPH decision making power for PP methods	Sex preferences	Not using a condom	Having money and demand of husband and in-law		Men or mothers do not respect the exact Shariah verses. Phrasing: In Quran sexual relations are strictly forbidden		
12	Low uptake of WPH/PHC counselling training	The respectful behaviour	Lack of sexual health knowledge	PHC no demand	Daughter in law does not have the same respect to her mother and father in law as she has to		The mother's role of parents, the social bond good and knowledge in culture		
13	Contraceptive system	Asking advice for having partners	Sex support	No involvement of men in women's health issues	Men to control husband's income and resources		Lack of parent's trust in religious leaders		
14	No clear intention of WPH and evidence not being in the	Many parent work in WPH	Wife of husband and wife's knowledge and skills	No involvement of men in contraceptive use and	parent poor consumption		Religious leaders wrong perception around sexuality		
15	Low safety net	Not sexual knowledge	Lack of knowledge about sexual and marital rights	No communication and understanding of women's sexual health needs	control and pregnancy complications and harm		My interpretation of Islamic law		
16	Completion of the WPH	patients are treated in spending and closing the patient symptoms via hormonal	Sexual, nutritional, underweight, insurance spending, blood, activated, Best pain, joints	Interference during her menstruation and past children	Having achieved of mother in law		Culture influence her beliefs/ values		
17	Religious impact of social media	Muslim Family right measurements	PHC, PHC, religious	Gender for rights rights	Gender communication, trust and understanding leads between mother in law and		According to Islamic law during periods a female should not		
18	Medical Ethics and regulations	No explanation of check-up/ deferring procedure. Patients stand on waiting machines with stress, lag	Peer access to health facility (not allowed), can't afford cost of transportation, no time	PHC use of Mobile phones and other source of social media			The Islamic ethics do not provide awareness for PP methods because it increases the level of emotional		
19	Continuity	WPH fragmentation on medicine distribution to patients. They decide distribution of some medicine in order to take for themselves, relatives or	Patients don't compare considered to be less choice of WPH visit	Isolation and marital challenges			to visit something should be medicine		
20	No clear description of human rights and gender equality training in the	Not knowledge of PP impacts and side effects	Peer educational knowledge PP available to her programme	Wife's wealth in case of divorce in husband's house					
21	Religious change among WPH approach	Long waiting time and reluctance to access	High demand for PHC and PHC gender diagnosis	Con-husband in order to avoid pain by multi-visit					
22	No action on sexual violence	No action for PHC, visiting record about it separately	No trust to WPH	Powerful and ability to decision making for going to a PHC					
23	No PHC fund in Afghanistan	No resources available in AWG, PHC and PHC	women rights and well being is not considered	children and pregnancy complications & harm					
24	PHC is working, it has conflict	No coordination of WPH and PHC	PHC health and considered as						
25	PHC should work 24 hours (evening in hospital WPH, health care, WPH)	PHC and PHC allows behaviour of WPH	Women evidence against woman						
26	Disparity in health care	Distressed	PHC to be allow how long to her						
27	Disruption by frequent visiting	No financial support for	No knowledge of financial health						
28	No review check of WPH	patients with related symptoms/conditions	PHC PHC health measurements						
29	No use of antibiotics	Patient's priority is not well	peer nutrition food issues						
30	The free clinic make people	Not well supported	Peer support about health						

A	B	C	D	E	F	G	H	I	J
Summary of Factors to Sexual & Reproductive Health Care Uptake and Provision									
No	H. System	HPs / HF's	Women	Husband	Mother in laws	Other family members & issues	Religious Leaders	Socio-cultural beliefs/ Traditions	
1	No enforcement of policy into practices	Child birth support	Young age marriage (Arranged, Forced, Bad, Badal, bride wealth)	Sexual assaults	decision maker	Father force her daughter for marriage	Against FP methods	God's will	Support and honour
2	In the health needs priorities, mental health is not included	Judgemental behaviour	Multi-Pregnancy (one after another) and high fertility rate	Verbal / Physical violence	childbirth support	Father obtains money (bride's wealth)	young age marriage is Lawful	Walwar, Toyana, Gala are the pride of a newly married girl or source of torture	Mental illness
3	no nutrition section in RH policy	humiliating and abusive behaviour	Home childbirth (barn room, toilet)	Financial supporter	Daughter in law to provide her services	Father never allow his daughter to go to school	any type of sexual activity with agreement of wife	sexual illnesses discussion is a taboo	Sexual health
4	Sexual health awareness section ?? In RH policy	Beating patients	Childbirth support (no one, Mother inlaw, neighboring women, TBAs)	Decision maker	Interferring in son and his wife life, sexual activities and food intake	Father and father in law are decision makers	Religious leaders demand for incentives in order to preach around human rights and women's health	baby girl birth depends on women	Family Planning
5	No organisation focus on Kabul health sector	Suffer from mental illness	mental illness	aggressive	Son preferences	No friendly behaviour of parents to children. Mother or father never discuss matters related to sexuality, puberty and changes in boys and girls genital organ	when a woman has no option other than be treated by a man. Other wise even if he is a doctor and visit him then it is na rawa.	Witch craft beliefs	ANC/ PNC
6	No mentions around Vasectomy in Policy. Not enforced other forms of contraceptives (condoms) for men	delays in decision making in HC provision.	Not allowed to go to HF's	watching porn movies	Against FP	communication gap between daughter in law husband and other female in laws	Pre-nancy is in hands of God	Virginity is proof of purity	Lack of trust
7	No HPs labouing law enforcement	Send on term patients back home	illiterate, do not know their age	illiterate	contraceptives make a woman dry, infertile , lead to poor eye sight	Joint family and lack of decision making power	Age of marriage, education and woman's rights are the contradictory ideas that religious leaders were discussing.	discussion about sexuality and genital organs are taboo	Violence
8	no inter-ministerial coordination	Communication & understanding gap between midwives and doctors	Miserable living condition	Multiwives	home remedies for placenta and childbirth delivery	families do not like to go to the courts	According to Islamic rules men and women have specific rights however women's rights is not discussed or explained to people.	various types of violence is perceived as common issue in Afghan context	Communication & Understanding Gap
9	No work commitment amongst NGOs and implementing organisations	Language barrier	heavy work during pregnancy	Son preferences	Mother in law and daughter in law's pregnancy competition	Bride's wealth for securing a woman's future or ruin her life?	.Women should know about their Islamic rights.	Poverty + more kids	
10	No M&E	Poor FP counselling	heavy work post childbirth	Against FP	make her son to abuse her daughter in law	Son is preferred but daughter is source of money	husbands should not hit women	God provides food and other required things	
11	No trainings outcome followup	Ignoring (ANC, PNC and FP, Maternity) practices . No PB, weight check, No physical	No support	Condoms cause kidney pain, foot pain	Bride wealth and more power for in laws to interfere to a bride's married life:		According to Mullahs Tub-igation and abortion is haram	our life problems impact on our daily work	

Appendix E. Assessment of Key Collaborators' Area of Activities, Projects and Their Role and Power for Successful Implementation of RH Policy

Collaborating Organisation	Area of Activity	Projects	Role and Power
International & Bilateral Partners			
USAID, United States Agency for International Development	<ul style="list-style-type: none"> - Assisted RH policy reform and development - Increase access to basic health services (BHS) and essential hospital services (EHS) - Increase the number of trained female providers including midwives - Improve community-based healthcare, health facilities construction - Improve the health behaviors of individuals, families, and communities □- Increase availability, demand for and access to quality products and health services through the private sector - Address the long-term sustainability of the healthcare system by strengthening the capacity of the MoPH at the national and sub-national levels. - Supported Afghanistan Demographic Health Survey (ADHS), Challenge for Impact Reproductive Age Mortality Survey (RAMOS) II and Afghanistan Mortality Study (AMS) 	<ul style="list-style-type: none"> - Health Service Support Project (HSSP) - Health Systems 20/20 - Partnership Contracts for Health (PCH) - Rural Expansion of Afghanistan's Community-based Healthcare (REACH) - Technical Support to the Central & Provincial MoPH (Tech-Serve) - Better Health for Afghan Mothers and Children Project - Communication for Behaviour Change (CBC): Expanding Access to Private Sector - Health Products and Services in Afghanistan (COMPRI-A) - Health Care Improvement (HCI) Project - Health Policy Project (HPP) - Central Contraceptive Procurement (CCP) - HEMAYAT: Helping Mothers & Children Thrive - Weekly Iron Folate Supplement Program (WIFS) 	Decision-maker in terms of RH policy reform Greater power for Immediate & Long-term implementation of all RH Policy components
JICA: Japan International Cooperation Agency	<ul style="list-style-type: none"> - Strengthening Health System - RH policy development and implementation <p>Financial Support: Afghanistan National TB Control Program (NTP) in their overall structural strengthening training reproductive health service providers in hospitals</p>	<ul style="list-style-type: none"> - Training for communities on maternal and neonatal health behaviour - Establishment of maternity waiting homes with necessary medical equipment (Donation of 40 ambulances) - Improvement of Maternal, Newborn and Child Health 	Decision-maker in terms of RH policy reform and some specific projects Greater power for Immediate & Long-term implementation of some RH Policy components
UNFPA: United Nation Population Funds	<ul style="list-style-type: none"> - Priorities the global program to reduce maternal, child and newborn health issues - Provide support to MoPH to develop/review/update policies, guidelines and strategic frameworks - Supported Afghanistan Mortality Study (AMS) and the Multiple Indicator Cluster Survey (AMICS) - Supports evidence-based policy-making - Supports organisational effectiveness and efficiency - Midwifery training program 	<ul style="list-style-type: none"> - Focused on gender-based violence and women's security, women's political participation and empowerment. - Supports government for implementation of human rights, elimination of gender-based violence, discrimination against women and prevention of young age marriage - Supports integrated SRH services, Evidence-based policy-making, Gender equality, Population dynamics, Adolescents and youth sexuality education and SRH services - Mobilize institutional and social structures to advocate and support rights-based family planning - Helps to enhance Afghans equity and to empower poor and marginalized people, especially women and adolescent 	Decision-maker in terms of RH policy reform Greater power for Immediate & Long-term implementation of all RH Policy components

UNICEF: The United Nations Children's Fund	<ul style="list-style-type: none"> - Support access to maternal health care services funded the construction of a special care neonatal unit - Supports policy development and technical advice to the MoPH. - Supports MoPH for improvement of Emergency Newborn and Obstetric Care - Development of Annual Work Plan for Weekly Folate Supplement Program (WIFS) - Coordinates with MoPH for implementing the Basic Package of Health Services (BPHS) 	<ul style="list-style-type: none"> - Improvement of Maternal, Newborn and Child Health in Afghanistan - Decrease the prevalence of malnutrition in pregnant and breastfeeding women. - Helps for the provision of maternal, neonatal care services, training of community health workers, prevention and treatment of malnutrition 	Decision-maker in terms of RH policy reform Greater power for Immediate & Long-term implementation of all RH Policy components
GF: Global Fund	<ul style="list-style-type: none"> - Funds for supporting national and regional programs for prevention, diagnosis and treatment of HIV&AIDS, Tuberculosis and Malaria - Scaling up innovative approaches to respond to TB challenges in Afghanistan - Strengthening Health System Initiatives in Afghanistan 	<ul style="list-style-type: none"> - Supports building a stronger health system by recruiting a larger number of community health workers - Implementing a robust health information system - Continues funding programs to fight against HIV&AIDS transmission as well as, diagnosis and treatment of Malaria and TB 	Decision-maker in terms of health policy reform and some specific projects. Long-term implementation of Some RH Policy related to TB, HIV&AIDS and Malaria prevention and treatment and HSS
CIDA: Canadian International Development Agency	<ul style="list-style-type: none"> - In Partnership with MoPH and other donors helps to reduce the vulnerability of the Afghan people, especially women, girls and boys - Supports Afghanistan Independent Human Rights Commission - Supported the System Enhancement for Health Action in Transition program (SEHAT) to improve national basic health services for women and children. 	<ul style="list-style-type: none"> - Helps for improvement of mother and child health - Supports projects that work to reduce the cultivation, production, trafficking and consumption of illicit drugs - Supports women and girls rights empowerment and equality 	Decision-maker in terms of RH policy reform and some specific projects Immediate & Long-term implementation of Some RH Policy related to Women's Rights, women equity and empowerment
WHO: World Health Organisation	<ul style="list-style-type: none"> - Technical support to MoPH to strengthen health system and reach development goals - Supports Policy development process - Establishment of capacity building trainings to midwives - Improving maternal and child health - Tackling malnutrition - Strengthening the building block of health system - Supports reproductive health research - Ensures right-based, gender responsive programs 	<ul style="list-style-type: none"> - Malaria prevention and treatment program - Prevention of TB and HIV transmission - Supports policy development through evidence based approach - Improving Immunisation and prevention of communicable diseases - Preventing non- communicable diseases (mental health, cancer, diabetes) - Promotes healthy life style - Improve Family Planning services - Capacity building of health professionals to conduct 	Decision-maker in terms of RH policy reform Greater power for Immediate & Long-term implementation of all RH Policy components
EU: European Union	<ul style="list-style-type: none"> - Reinforcing women's psychological well-being - Empowering women and strengthening their role in Afghan society - Supports BPHS - The System Enhancement for Health Action in Transition (SEHAT) program - Provides capacity building to the Ministry staff and operates in 22 provinces ensuring BPHS and EPHS delivery 	<ul style="list-style-type: none"> - Assisting social and legal protection of violence survivors - ECHO (European Commission Humanitarian Aid) help provide life-saving emergency medical care, food assistance, protection, shelter, water and sanitation, hygiene promotion, and livelihood support to people affected by conflict and natural disasters. - Women's capacity building and improving their living condition 	Decision-maker in terms of RH policy reform and some specific projects Greater power for Immediate & Long-term implementation of Some RH Policy related to Women's psychosocial well-being, women empowerment

WB: World Bank	<ul style="list-style-type: none"> - Implementation Support BPHS - Strengthening hospital management - Population and reproductive health - Gender equity - Strengthen gender equality - Supports reduction of maternal mortality ratio and high fertility rate 	<ul style="list-style-type: none"> - To influence policy and program design in order to increase girls' educational attainments, especially in higher secondary schools in rural areas - HIV/AIDS prevention - Strengthening the capacity of CHWs - Provide additional funds especially for 'Result Based Financing' health programs 	Decision-maker in terms of RH policy reform and some specific projects Greater power for Immediate & Long-term implementation of Some RH Policy
GAVI-HSS: Global Alliance for Vaccine and Immunization Health System Strengthening	Provides financial support for strengthening health systems, target service delivery barriers, (Reduce child mortality and improve maternal health	<ul style="list-style-type: none"> - Improved and sustained immunization and maternal health care outputs in the health system - Improving access to health services - Immunisation support 	Greater power for Immediate & Long-term implementation of RH Policy related to immunisation and HSS
International Implementing Organisations (NGOs)			
SHARP: Strengthening Health Activities for the Rural Poor Project	Funded by WB Supported implementation of BPHS and EPHS Strengthening health services in rural areas	Provided Result Based Financing health programs Increase women access to health care services	Ineffective role (could lead to under or over-reporting of visits in order to obtain financial supports
The Aga Khan Foundation (AKF)	Received funds from JICA to -Supports Health promotion and disease prevention education activities at the community level.	Community-based health care is linked with health service delivery units from basic health centers up to full-fledged hospitals. - Support to maternal and child health programs in rural areas through community members capacity-building	Effective Long-term impact
BRAC	Received funds from USAID, and GF Supporting provision of essential healthcare, prevention and treatment of malaria and tuberculosis (TB), Supporting Antenatal and post natal care services	Supporting Community Health care promoters. Works with the country's National Tuberculosis Program (NTP) Improving access to healthcare and the overall health status of the poor, particularly women and children.	Effective immediate and long-term role. Supports 42 health facilities
MSI: Marie Stopes International	The major external funding to MSI Afghanistan comes from the Swedish Development Authority (SIDA), the Finnish Ministry of Foreign Affairs, the UK Department of International Development (DFID), small project from NORAD through MSI core fund and small private foundations. Provides reproductive and maternal health services via our 12 centers in central, southwest and northern Afghanistan. Supports social marketing of Contraceptives through community based distributors and private health sector and demand generation for birth spacing	Supports policy improvement for SRH and SRH rights, capacity building of the government and private sector, SRH / maternal and child health service delivery. - Supports safe abortion and post abortion care - Helps prevention of HIV&AIDS - Supports marketing officers for selling contraceptive products door to door and within some health centers	Could have an effective immediate and long-term role if their project objectives are paralleled with RHD/FP Policy
MSF: Médecins Sans Frontières	Relies on private funds/ Humanitarian non-profit Provides on going health services in 4 province of Afghanistan mainly maternal and child health services in	Supports maternal health services (ANC, PNC, Emergency Obstetric Care, maternity) Capacity building training for health staff	Very effective immediate and long-term role

	District hospitals - Mobile health teams go to remote areas	Providing free and high-quality medical care and medicine	
REACH	Received Funds from USAID, -Health Education to Community Health Workers (CHW), Nurses, Midwives and doctors to communicate effectively with those they serve.	- Produced radio spots and dramas in both Dari and Pashto that educate listeners on healthy practices and promote behavioural change. - Produced and distributed a variety of health education materials (picture messages/ posters) designed to educate a largely non-or semi-literate population to promote their health status	Very important role for BCC/ IEC improvement
AFGA: The Afghan Family Guidance Association Since 1968	Receives Funds from IPPF (International Planned Parenthood Federation) AFGA's Family Welfare Centers in three provinces of Afghanistan (Kabul, Herat and Jalal Abad) supports SRH and psychosocial counselling and referral of complicated cases to hospital departments - Runs Youth Health line (Calling Centre) in Kabul in partnership with UNFPA - This organisation used to distribute food supplements to pregnant women 40 years ago.	Provides information on Family Planning methods and free contraception; - Counselling on family planning, adolescent health and HIV and AIDS prevention and treatment; antenatal and post-natal care - Screening and treatment of sexually transmitted infections (STIs); basic infertility treatment; - Training of Faith-Based organisation members - Support trainings related to GBV - Published Book about Religious beliefs and Family	Effective immediate and long-term role in terms of RH services, free contraceptives distribution, psychosocial counselling and sexuality education and promoting SRH awareness through Religious leaders
Health Net TPO	The on-going support of 15 female focal points in each of the target provinces through Community Resource Mapping and Mobilization (RMM) project Funded by European Commission, UNIFEM, Save the Children - Reduction of violence and discrimination through human rights and Islamic rules awareness - Women empowerment through vocational trainings (Embroidery, carpets Weaving, literacy, tailoring, poultry) - Distribution of free bed nets this project funded by Global Funds and LSHTM - Through public-private partnerships (PPP) project which is funded by WHO improved public access to quality health services (reproductive health and Immunisation services) in remote areas	Enables women to set up local (sub) groups in order to generate plans and actions towards an increase in their autonomy. - Support Jalal Abad hospital with Secondary Health services - At the community level topics related to stress management, health and hygiene, women's rights, coping with family violence, peace building, gender in Islam, children's rights, vaccination are discussed - Training of local health services providers for diagnosis and treatment of Malaria - Conducted training to private health service providers and supply of essential medicine - Improving health ad hygiene awareness	Effective immediate and long-term role in terms of community resource mobilization, peoples awareness about health, hygiene and human rights according to Islamic beliefs, reduction of violence, women's empowerment and health staff capacity building
IPSO: International Psychosocial Organisation	Funded by the German Foreign Office and the European Union - Developed and published Learning Resource Package (LRP) for the training of Psychosocial counsellors. - Trained 180 health service providers about bio-psychosocial and mental health care Professional counselling will be delivered through the public health system (BPHS and EPHS - 50% downsized due to budget constraints in 2012	- Supporting the integration of mental health and psychosocial counselling services into the public health system of Afghanistan - Training health staff, psychosocial counsellors, medical doctors and nurses working in primary and secondary health care of selected clinics in all provinces. - Started a new project aiming at reducing violence against women in Afghan families. Women and families will be encouraged in the participatory process of the counselling	Could have sufficient long-term impact if referral system is improved and this organisation have a strong commitment and expand its services to a larger number of health facilities
IMC International	Relies on private funds/ Humanitarian non-profit Agency - Strengthening the capacity of the Ministry of Public Health,	- Ensure that medical and psychosocial support is available for survivors of GBV through health facilities and community-based	Very effective immediate and long-term role

Medical Corps	<ul style="list-style-type: none"> - Fostering fundamental behavior change at the community-level - Using sustainable interventions. - Provides Mental health and Psychosocial support Implemented three hospital management programs throughout Afghanistan - Provided community midwifery education 	<p>support</p> <ul style="list-style-type: none"> - Established “One Stop Assistance Centers,” where GBV survivors can receive legal counseling, psychosocial support, and medical referral. - Provided technical training for doctors, nurses and psychologists; English and computer training for all the Maternal health hospitals staff 	However no prominent role in RH Policy reform
Relevant Ministries			
Ministry of Woman Affairs (MoWA)	<p>Reviews issues around maternal and neonatal health (MNH), Family Planning (FP), Gender issues, Sexual Transmitted Infections (STIs) and HIV&AIDS advocacy programs in RH policy and strategy</p> <ul style="list-style-type: none"> - Coordinated with MoPH to provide health information related to Prevention of HIV, hygienic environment, mental health and sexual health 	<p>There is need for close coordination and ensure the implementation of gender rights and gender-based violence Issues which is in Gender and advocacy</p> <p>MoWA could advice on how to respond to RH needs and could enforce related RH regulatory framework and advocacy</p>	Do not have prominent role due to the lack of commitments and budget constraints
The Ministry of Education (MoE)	Coordinate in Information, Education and Communication (IEC), Behavioural Change Communication (BCC)	<p>Inclusion of reproductive health curriculum in the schools subjects</p> <p>Implementation of Family Health Worker Projects, which is a joint MoPH and MoE Projects could be effective</p>	Do not have prominent role due to the lack of coordination
Ministry of Higher Education (MoHE)	Coordinate in Information, Education and Communication (IEC), Behavioural Change Communication (BCC) And pre-service training	Inclusion of reproductive health curriculum in the higher education. Implementation of Family Health Worker Projects, which is a joint MoPH and MoE Projects could be effective	Do not have prominent role due to the lack of coordination
Ministry of Communication & Information Technology (MCIT)	Coordinate in Information, Education and Communication (IEC), Behavioural Change Communication (BCC) and pre-service training	Commitments to connect national health facilities to the main hospitals and international health institutions; in order to improve quality health services and people even in rural areas could have distance medical services	Do not have prominent role due to the lack of coordination and commitment
MoJ Ministry of Justice & Ministry of Hajj and Religious Affairs MoHRA	They could play a significant role in implementation of health policy and strategy based on the rule of law (maternity leave laws) and Islamic views.	No sufficient funds/incentives to implement issues around child marriage and child-spacing (since these have major impact on age of first pregnancy associated with mental health issues)	Do not have prominent role due to the lack of coordination and commitment
Ministry of Agriculture, Irrigation Livestock	Support MoPH/RHD in reviewing topics in relevance to the food supplements for women and children, their nutritional status and substitution of breast milk.	This ministry could help food supplement distribution to pregnant women who suffer from malnutrition.	Do not have prominent role due to the lack of coordination and commitment
Ministry of Rural Rehabilitation & Development (MRRD)	Ensure health services are expanded in the remote areas and people have access to health facilities	Could support people in clean drinking water and sanitation	Do not have prominent role due to the lack of coordination and commitment
National Partners / NGOs			

Civil Society	There are no active participation of civil society in terms contribution in RH policy reform however some civil society workers provide psychosocial support, reproductive health, women's rights awareness and skill development and micro-credit support	e.g. community councils and religious leaders committees could play a significant role in terms of RH policy implementation	Could have an effective role if MoPH support their contribution
(WAW) Women for Afghan Women	WAW is a civil society community-based organisation protecting and supporting women and girls rights. This organisation helps provides safety shelters for women and girls who are survivors of various type of violence -Promotes women and girls empowerment and self-determination and promote their active participation in all sectors.	- Provides legal aid and family guidance centers, psychosocial support and long-term safety shelters for women and girls of 13 provinces of Afghanistan -Conduct human rights related trainings to law makers, religious leaders and community members	Do not have prominent role. This organisation could play a significant role in terms of SRH and Rights Policy reform and implementation.
(AIHRC) Afghanistan Independent Human Rights Commission	- Works on promotion, protection and monitoring of human rights in Afghanistan - Provides advice to the government for better implementation of Afghanistan's commitments to international human rights conventions. - The AIHRC works with collaboration of government and non-governmental authorities, civil society institutions, religious scholars, media, and international institutions to improve the implementation of human rights standards and raise the level of human rights observance in relevant area	- Assessment, monitoring and follow up and provision of legal advices on cases related to gender-based violence, honour killing and human rights violence and abuses. - Carrying out research to find effective ways of harmonizing principles and mechanisms of international human rights instruments with Afghan culture and national traditions and making suggestions in this respect	Do not have prominent role. This organisation could play a significant role in terms of SRH and Rights Policy reform and implementation.
Private Sector	Quality RH services by health professionals based on National Standards. Private sector supports RH service provision, laboratory and diagnostic services, Family planning methods and medicine	Could have an effective role and contribution in RH policy reform and implementation. Private sectors supports 49 health facilities in Kabul	Effective immediate and long-term role.
Mass Media	Radio, TV, newspapers, magazines and social media could promote Information, Education and Communication (IEC), Behavioural Change Communication (BCC)	There is lack of funds. RH related topics discussion, educational TV spots, Radio RH awareness messages could have a great impact on people's awareness and health seeking behaviour	Could have a major influence on RH policy reform and implementation if their collaboration and commitments are supported by MoPH

Sources: USAID,-Afghanistan Available at: <https://www.usaid.gov/afghanistan/health>, Global Fund: <http://www.theglobalfund.org/en/portfolio/country/?loc=AFG>

UNFPA: <http://www.unfpa.org/transparency-portal/unfpa-afghanistan> and <http://www.unfpa.org/sites/default/files/portal-document/UNFPA-GOIRA-CPAP-2015-2019-EN-Signed.pdf>, CIDA:

<http://www.acdi-cida.gc.ca/cidaweb/cpo.nsf/fWebCSAZEn?ReadForm&idx=00&CC=AF#countryonly>, MoPH : <http://moph.gov.af/en/page/527>

WB: <http://search.worldbank.org/all?qterm=Afghanistan+reproductive+health&title=&filetype>, EU:

http://eeas.europa.eu/delegations/afghanistan/eu_afghanistan/development_cooperation/index_en.htm And

http://eeas.europa.eu/delegations/afghanistan/eu_afghanistan/development_cooperation/social_protection/index_en.htm, WHO: <http://www.emro.who.int/afg/who-in-afghanistan/programmatic->

[areas-of-who-afghanistan.html](#), GAVI alliance: <http://www.gavi.org/country/afghanistan/>, BRAC <http://afghanistan.brac.net/health>, MSI: <https://mariestopes.org/where-in-the-world#afghanistan>, MSF: http://www.msf.org/sites/msf.org/files/msf_international_activity_report_2014_en.pdf#page=24, Health Net TPO : <http://www.healthnettpo.org/en/23/healthnet-tpo-in-afghanistan.html>, IPSO: <http://ipsocontext.org/projects/current-projects/afghanistan/>, AIHRC : <http://www.aihrc.org.af/home/introduction>, WAW: <http://www.womenforafghanwomen.org/#!page-3/cqg>, IMC: <http://internationalmedicalcorps.org/document.doc?id=120> and <https://internationalmedicalcorps.org/afghanistan>

Appendix F. A Section of Research Ethics Form with Amendments

(Yellow highlights)

SCHOOL FOR MEDICINE AND HEALTH APPLICATION FORM FOR ETHICAL REVIEW AND APPROVAL OF WORK WHICH INVOLVES HUMAN PARTICIPANTS AND/OR GIVES RISE TO ETHICAL ISSUES

1.11 What is the principal research question or objective?

To frame applicable and appropriate interventions for sustainable maternal health service uptake and access to antenatal (ANC), child birth and postnatal (PNC) care practices in Afghanistan.

1.12 What are the secondary research questions or objectives?

I recognise that within the given time frame it will not be possible to address all secondary research questions. The specific secondary research questions will develop over the course of the fieldwork as understanding of emerging themes is gained.

- To understand the impact of political instability and insecurity on the maternal health care uptake in Afghanistan.
- To register an account of the impact of a poor health system on the quality of maternal health care (ANC, childbirth and PNC) provision and individuals' well being.
- To develop an understanding of the behaviour of maternal health care providers (doctors, nurses, skilled birth attendants, other staff, community health providers and traditional birth attendants) towards pregnant patients in a facility - based in services practices and at the community level.
- What attitudes towards women are expressed by health care providers in different care contexts and how do these impact on women's willingness to seek/ source maternity care?
- What are the main contextual barriers (social, cultural and institutional) to maternal health care and how are these problems discussed in the various Afghan ethnic and socioeconomic contexts?
- What are the roles of other members of the family in influencing pregnant women's seeking either modern maternal health care services or more traditional maternal health care?
- How do the socio-cultural perspectives of different Afghan communities affect the provision and uptake of maternal health care in Afghanistan?
- How are maternal health care decisions made within households and

communities and with what implications?

- What are the detrimental impacts of ethnicity, cultural and linguistic barriers to maternal health seeking in Afghan context? Alternatively what aspects of these promote maternal health seeking behaviour?
- How and to what extent, does the wide spread of addiction to opium impact the dynamics of health seeking behaviour within households?
- To what extent do various health organisations and institutions use maternal health projects for their political and economic interests and how does this affect women's perceptions of health provision in general, and behaviour within households and maternal health care in particular?

1.13 What is the scientific justification for the research/project?

The Afghan government estimated a high maternal mortality ratio (MMR) (327 per 100,000 live births) among Asian countries. However, due to inadequate reliability of data, the extent of maternal mortality and morbidity ratio remains unknown. As a result of multifaceted barriers in diverse Afghan ethnic groups, the provision and uptake of quality maternal health care services (antenatal, childbirth and postnatal) remain limited. As yet, no ethnographic work has been conducted in Afghanistan to examine how institutional and structural barriers to maternal health care play out in the lives of women from different ethnic and linguistic groups. Therefore no policies have yet been developed to specifically address institutional and ethnically-specific structural barriers to improving the provision of and access to antenatal and postnatal care services.

1.14 Please give a summary of the research/project design and methodology:

This research is a mixed qualitative ethnographic and narrative study. Participant observation combined with semi-structured interviews, focus group discussion and life narrative will be applied for the purpose of data collection. Obtaining diverse information from respondents will create an in-depth understanding of the main issues and key barriers in the Afghan context. Furthermore, collecting the data from various ethnic groups and communities may help to identify strategies for culturally-appropriate intervention to increase maternal health care uptake and quality health service provision.

1.15 Where will the study take place?

(include all locations both at and external to the University)

A study using two geographical sites (Eastern and Western districts) in Kabul-

Afghanistan, with the diversity of ethnic groups (Pashtun, Tajik and Hazara) is proposed for this research. The Dashte Barchi and Pule khoshk are very poor settings in western Kabul city. In comparison with this area, the second locations are situated in eastern part of Kabul district (Ahmad Shah Baba Mina and Bagrami).

1.16 Statistics:

Is statistical review required for this study?

- Yes No

If YES, from whom has statistical review been sought, and what was the outcome of their review?

If NO, explain why statistical review is not required.

This study will involve qualitative methods only.

1.17 Sample Size:

i) How many participants are to be recruited – please give either an exact figure or a maximum?

This will be a stratified sample comprised of different interested parties: pregnant women, women who have recently given birth, husbands, other family members, community members / leaders, staff of health facilities and health and gender based activists and counsellors. Numbers of participants will depend to a large extent on the ethnic diversity of women attending the health facilities in each location and the number of contacts I make through the health facilities/community health providers/traditional birth attendants. The selection of participants depends partially on the ethnic diversity and willingness of initial parties in each location (more ethnic groups means more potential participants). It is possible across two sites, multiple ethnic groups and various health care staff, that potential participants/indicative numbers total more than 200. This is comprised in each site of 3 ethnic groups x 5 women x 5 family members per woman + 2 community/religious leaders + (6 x specific health professions in each location, especially doctors, nurses, therapists, traditional birth attendants, community health workers, health educators and, health and gender based activists and counsellors). (But not all health professions will be present in each care site.)

ii) Please describe the statistical/other rationale for the sample size/number of participants to be used in this study and how the study size will yield meaningful results.

As this is a qualitative study there is no statistical rationale for designing sample sizes. In order to keep the numbers manageable, I need to make wise choices about which participants to include in the study. After approval from the Durham University Ethics Committee, the approval letter along with other relevant supplementary documents will be sent to the Ministry of Public Health Institutional Review Board. The MoPH IRB will be asked for permission at the official level from the Afghan MoPH to recruit Health care providers in the public and private health facilities.

Due to the nature of the research the recruitment of participants is subject to the participants' willingness to speak freely about various difficult issues, the development of particular themes within the data and the constraints of time to collect, transcribe, translate and analyse the data. Ideally I would continue to recruit participants until data saturation on the selected themes is achieved however I recognise that it may not be possible within the given time frame.

The culturally, permissible way to contact women in Afghanistan is through personal introduction of other women, TBAs or CHPs. Sometimes women will accompany me to other women's houses who are pregnant or have recently given birth. Due to the patrilineal system in Afghanistan, the household head or gatekeeper's consent is crucial for many purposes 1). To obtain access to the home 2). To observe or interview each household participant 3). As potential participants in their own right.

The household head's consent will confirm the pregnant women or other family members' participation in the study however after obtaining the household head's consent I will also seek the consent of pregnant woman or women who have recently given birth.

After being introduced to the household members, I would share a copy of the participation information sheet and seek the consent of a pregnant woman or a woman with a young child, her husband and other family members for taking part in the study. By applying a less intensive approach (multiple in-depth case studies), I will focus on maternal health care uptake and provision issues as consequences of sociocultural, economic and political aspects in greater detail.

iii) Please describe the intended methods of analysis by which the data that is generated by the study will be evaluated to meet the study objectives.

Ethnographic data analysis / systematic coding (constant comparison) using computer assisted NVivo software

1.18 Peer Review:

i) Please select to confirm that this project has been peer reviewed

Yes

ii) Please provide details of who has peer reviewed the project and what their opinion of the project is.

My primary supervisor has done the peer review (see the attachment) but both supervisors have had detailed discussions about the project design and feasibility with me.

iii) Please provide details of how these comments have been incorporated into this project or provide justification for not incorporating the comments

My primary supervisor's views and comments regarding the field work, the recruitment of potential participants (which is subject to the development of particular themes within the data), the participant observation and the time constraints to collect, transcribe, translate and analyse the qualitative data have been incorporated into this project. In addition, my primary supervisor did not think the proposed number of interviews was feasible and that I would be making clear informed choices about which patients to follow and which people to interview as the data collection reveals themes that are worth pursuing.

Please attach a copy of the peer review with your application.

1.19 Qualitative Review:

i) Does this project include any qualitative elements?

Yes

No

ii) If yes, does the research team include a qualitative researcher

Yes

No

iii) If yes, Please provide details for the qualitative researcher(s) on the research team

The principal investigator will conduct the qualitative research.

iv) If no, please provide details of who has reviewed the qualitative elements of this project and their comments.

Both my supervisors have reviewed the qualitative elements of this project.

v) Please provide details of how these comments have been incorporated into this project or provide justification for not incorporating the comments

The following comments will be incorporated into this project:

Although all the secondary questions are important and interrelated, I will not be able to focus on all of these in this PhD project. It's not feasible in the given time frame.

I will be making selections about what to focus on as i) the research unfolds ii) the snowballing highlights which groups of women I can follow and iii) the observations reveal which concerns are most important to the women I am following. There is a need for the Ministry of Public Health guidance on what they require to demonstrate that heads of household have given their consent?

I aim to conduct Focus Group Discussions or one to one interviews during my second phase of data collection to obtain a reflexive interpretation of health professionals, health and gender based activists and counsellors and religious leaders' perceptions around women's sexual health issues during reproductive life cycle and explore the best applicable and feasible short and long term approach in Afghan context.

SECTION 2: RECRUITMENT OF PROJECT PARTICIPANTS

2.1 Who are the Participants?

Pregnant women, their husbands and other household members, mothers of young children, health care providers within public and private health facilities and coordinating non governmental organisations, community health providers, Psychiatrists, traditional birth attendants and community/ religious leaders.

Please note:

Research involving (but not limited to) subjects under 5 years of age or persons known by Investigators to be pregnant must be referred to the Insurance Officer at an early stage so that appropriate insurance cover can be confirmed before the research commences.

Intrusive research involving adults without the capacity to consent must comply with the requirements of the Mental Capacity Act 2005 and requires approval by an NHS Research Ethics Committee or the Social Care Research Ethics Committee (SCREC).*

**Intrusive research is defined as research that would be unlawful if it was carried out 'on or in relation to a person who had capacity to consent to it, but without their consent'.*

2.2 SELECTION CRITERIA:

i) Inclusion criteria (please list the principal inclusion criteria for participants)

Participants from various ethnic groups (mainly Pashtun, Tajik and Hazara) of any educational background will be included in the research. Inclusion criteria: consists of:

- Married, pregnant women and women who have recently given birth.
- Husbands and other household members
- Religious and community leaders
- Community health care providers and traditional birth attendants
- Health staff (doctors, nurses, midwives other personnel)
- Staff of many non governmental organisations who are providing health care awareness and counselling services

ii) Exclusion criteria (please list the principal exclusion criteria for participants)

- Non relevance to the research topic health issues
- International health agencies' staff
- The Afghan Ministry of Public Health authorities
- Prisoners
- People who are mentally incapacitated
- People who are members of arm forces
- Children

iii) If participants are students please state their course and year of study:

N/A

2.3 i) Do participants have a link to the principal applicant or other members of the research team (student, friend, etc.)?

Yes No

ii) If yes, what safeguards are in place to preserve objectivity and transparency and to prevent conflicts of interest?

N/A

SECTION 3: CARE AND PROTECTION OF PARTICIPANTS

Please note: section 3.7 – 3.11 may be forwarded to the Health and Safety Co-ordinator for the School of Medicine and Health by the Secretary of the SMH ethics committee.

- 3.1 Please describe briefly what will happen to the participants – interviews, questionnaires, the anticipated duration of each, number of sessions, intervals between sessions, and give the total amount of time that a participant will be in the study.

Semi-structured interviews

- With health care providers and Health workers of coordinating non-governmental organizations will take a maximum of one and half hour.

Observation of

- The health staff's routine and emergency health care provision
- Women's daily lives
- Behaviour of family members
- Traditional birth attendants and community health worker's practices

I will need to judge how useful each observation is to assess the time devoted to each participant and the time lapse between each observation and between observations and interviews.

Focus Group Discussions

- Health professionals at the District Hospitals and Comprehensive Health Clinics
- Health workers of coordinating non-governmental organizations.
- Religious leaders
- Civil Society activists who are running reproductive health awareness and counselling programs

Will take place over an extended period of time (around 12 months).