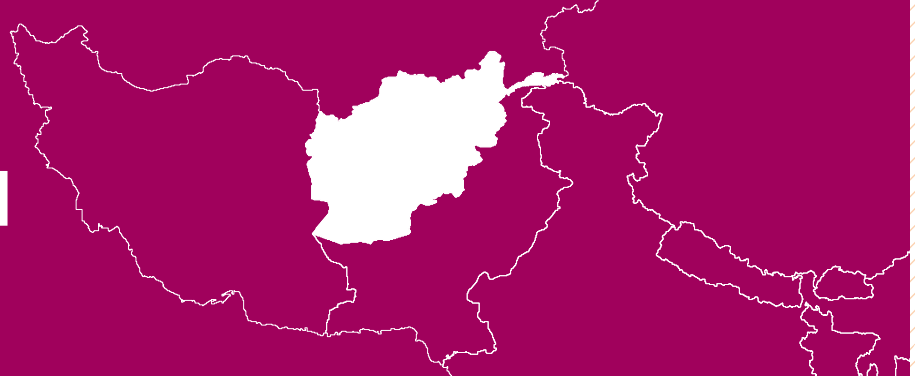
# AFGHANISTAN

## PAC-FP COUNTRY BRIEF



**Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the government of the Islamic Republic of Afghanistan's investment in providing PAC and FP services to women in need.**

## POLICIES, LEADERSHIP, AND GOVERNANCE

The government of the Islamic Republic of Afghanistan's national policy on family planning (FP) and reproductive health (RH) is outlined in a number of documents, including the Reproductive, Maternal, Newborn and Child Health Strategy 2016–2020 (2016) and the Ministry of Public Health (MOPH) Policy 2016–2020 (2016), and the National Health Policy 2015–2020 (2015). Specific guidelines discussing postabortion care (PAC) include the National Standards for Reproductive Health Services: Family Planning Service Guidelines for Birth Spacing (20013) and the National Standard Treatment Guidelines for the Primary Level, MOPH, Afghanistan (2013).

Afghanistan's PAC National Clinical Service Guideline (2017) covers the three main components of PAC: treatment of complications, FP (including community links and community awareness), and abortion prevention. The revised guideline includes methods recommended by the World Health Organization (WHO) for the treatment of incomplete abortion (manual vacuum aspiration and misoprostol); emphasizes the importance of high-quality FP counseling and voluntary service provision (integrates Balanced Counseling Plus strategies and other national FP strategies into postabortion FP counseling); and provides specific language and strategies for respectful and bias-free treatment of all women (including adolescents) through the expansion of the respectful maternity care framework to include PAC services.

This policy also discusses capacity building and the MOPH's commitment to provide comprehensive emergency obstetric and newborn care, where performing manual vacuum aspiration is included as a single function.

### *Legal Status on Abortion*

According to Afghanistan's Penal Code of 1976, abortion is only permitted to save the life of the woman.

## PAC TRAINING AND STANDARDS

Afghanistan's Postabortion Care National Clinical Service Guideline addresses complications related to spontaneous and induced abortions by improving treatment and linking women to FP and other RH services. This guideline and the PAC Training Package include detailed technical information on PAC management and treatment. These two documents present national PAC policies and serve as technical resources with references to other resources, including USAID's ACCESS PAC package. These documents provide information related to respectful care, initial assessment and decision-making, uterine evacuation methods (including vacuum aspiration and misoprostol), pain management, postabortion FP counselling and method provision, monitoring and supportive supervision of quality postabortion care, and infection prevention. The government developed the PAC guideline and training package for use at the national level and has not yet finalized plans for the selection of provinces and institutions for implementation.

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients

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The government designed the PAC curriculum for use in conjunction with the Afghanistan FP Curriculum. The FP curriculum covers all methods (including long-acting reversible contraceptives and permanent methods) as well as FP for clinical conditions and counseling for method choice. In addition to FP guidelines, the Balanced Counseling Strategy Plus, a toolkit for FP providers, is now available in local languages for general FP programs and can also be used for PAC. Providers can now receive training on the strategic provision of FP, including interim FP, postabortion FP, and postpartum FP. The 2017 PAC Facilitator Guide and PAC Participant Guide include skills checklists, pre- and posttests, session plans, case studies, and other tools for training.

## STRENGTHENING SERVICE DELIVERY

Afghanistan revised the PAC National Clinical Service Guideline and PAC Training Package to enable healthcare providers to gain knowledge and skills for the provision of quality PAC, as well as to prepare sites to deliver services according to the guidelines. The country has furthermore mapped partners and mobilized resources to plan and conduct a national training-of-trainers and cascade the training to expand services accordingly.

With funding from the U.S. Agency for International Development (USAID), the Helping Mothers and Children Thrive (HEMAYAT)[1] project is supporting the introduction, scale up, and sustainability of high-impact FP and maternal and newborn health interventions in Afghanistan. The project is working to increase access to, utilization of, and demand for voluntary, high-quality, gender-sensitive FP and maternal and newborn health services provided by the MOPH's Basic Package of Health Services (BPHS) implementers and the private sector. One of HEMAYAT's objectives is to support preservice midwifery education. Working in collaboration with the Afghanistan Midwives Association, the program aims to update educational standards and tools in line with the WHO's core midwifery competencies.

[1] (https://www.usaid.gov/sites/default/files/documents/1871/HEMAYAT_-_August_2017.pdf)

## BARRIERS TO PAC

Women in Afghanistan face multiple barriers to accessing PAC and FP services. Cultural issues, including the need for female providers to serve women, women's inability to make health-related decisions autonomously, and gender roles that promote high fertility and similar expectations are the main barriers to women's access to PAC and FP services. Compounding these cultural barriers is low community awareness of these issues.

Financial concerns due to out-of-pocket payment requirements, inadequate capacity of healthcare providers to perform quality services, lack of infrastructure (especially in rural areas) and insufficient resources pose further challenges for women. For examples, misoprostol tablets are not included on the BPHS essential drug list and are therefore not available at health facilities; studies have also found that manual vacuum aspiration kits are not always available at health facilities.

Security issues also make it difficult to provide quality healthcare services and can limit physical access. Security issues similarly limit the availability of and result in a high turnover of skilled birth attendants.

## FINANCING MECHANISMS

Afghanistan does not have a national health insurance program. However, FP services are available for free through the BPHS and Essential Package of Hospital Services (EPHS). Additionally, all health services provided at primary and secondary levels (BPHS and EPHS packages) are free, in accordance with Afghanistan health policy.

PAC is highly donor-sensitive in the country. If international donors provide financial support for PAC, Afghanistan's MOPH is committed to deliver and integrate PAC as an important component of RH programming. However, a reduction in donor support in PAC is likely to stall the provision of these services.

| AFGHANISTAN | | Year | Source |
|---|---|---|---|
| **Demographic/background indicators** | | | |
| Country population | 36,530,081 | 2017 | World Bank[2] |
| Total fertility rate | 5.3 | 2015 | Demographic and Health Survey, 2015 |
| Age at first birth | 20.1 | | |
| Maternal mortality per 100,000 live births | 1,291 | | |
| Newborn mortality per 1,000 live births | 22 | | |
| Infant mortality per 1,000 live births | 45 | | |
| Under-five child mortality per 1,000 live births | 55 | | |
| Facility-based deliveries | 48% | | |
| Proportion of women who attended at least one antenatal visit | 62% | | |
| Proportion of women who received a postnatal check after live delivery | 44% | | |
| **Abortion and FP-related indicators** | | | |
| Number of women receiving PAC, per facility | 244 | 2009–2010 | Ansari et al. |
| Proportion of providers that reported receiving PAC training | 70% | 1009–2010 | |
| Number of unintended pregnancies | 643,000 | 2017–2018 | FP2020 Core Indicator 2017–18 Summary Sheet |
| Number of unintended pregnancies averted due to use of modern contraceptive methods | 407,000 | | |
| Number of unsafe abortions averted due to use of modern contraceptive methods | 163,000 | | |
| Number of maternal deaths averted due to use of modern contraceptive methods | 910 | | |
| Modern method contraceptive prevalence rate , all women of repoductive age (WRA) | 13.9 | | |
| Knowledge of FP, currently married women | 95% | 2015 | Demographic and Health Survey, 2015 |
| ***Contraceptive use by type*** | | 2017–2018 | FP2020 Core Indicator 2017–18 Summary Sheet |
| **Long-acting and permanent methods** | | | |
| Sterilization (female) | 9.1% | | |
| Sterilization (male) | 0.0% | | |
| Intrauterine device | 7.1% | | |
| Implant | 1.0% | | |
| **Short-acting methods** | | 2017–2018 | |
| Injection (intramuscular and subcutaneous) | 24.9% | | |
| Pill | 34.5% | | |
| Condom (male) | 16.8% | | |
| Condom (female) | 6.6% | | |
| Other modern methods (e.g., cycle beads, and lactational amenorrhea method) | 1.5% | | |
| *Unmet need for FP*[3] (2018) | 25% | 2017–18 | Demographic and Health Survey, 2015 |
| Unmet need for birth spacing | 18% | | |
| Unmet need for limiting | 7% | | |
| Percentage of all women who received FP information during their last visit with a health service provider | 23.0% | 2017–18 | FP2020 Core Indicator 2017–18 Summary Sheet |

[2] https://data.worldbank.org/country/afghanistan

[3] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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