Journal Homepage: - www.journalijar.com
INTERNATIONAL JOURNAL OF ADVANCED RESEARCH (IJAR)
Article DOI: 10.21474/IJAR01/5271
DOI URL: http://dx.doi.org/10.21474/IJAR01/5271

RESEARCH ARTICLE

DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER OF PUBLIC HEALTH.

Noor Hassan Shirzad.
Jodhpur School of Public Health (JSPH). Maulana Azad University, Jodhpur, India.

Manuscript Info

Manuscript History

Received: 24 June 2017
Final Accepted: 26 July 2017
Published: August 2017

Key words:-
Ridge splitting, Expansion, Guided bone regeneration.

Abstract

Rational: Family planning is globally recognized as a key life- saving intervention for maternal and child health, it is one of the important components of Reproductive health strategy of the country. There for realizing of Family planning knowledge, attitudes and practices among women is quite necessary.
Objectives: To estimate the knowledge, Prevalence and attitude toward Family planning among married women of reproductive age (15-49) in Helmand.
Method: A Cross-sectional study is conducted in outpatient department of two health facilities, Kart-e-lagan CHC and Nadali CHC in two districts of Helmand province. A convenient sample of 384 married women from reproductive age selected attending outpatient department of health facilities.
Population: Total population was 384 married women attending outpatient departments of Kart-e-lagan and Nadali CHCs.
Time Frame: The study took total of 38 weeks from its start up to draft of final report.
Results: The study showed that knowledge of modern contraceptives among respondents were high, 92% of women heard of family planning, majority of them heard from health care providers. Women preferred healthcare providers for seeking counseling regarding Birth spacing. 58% women used any modern contraceptive method, and 20.9% were currently using any modern method. 27.4% intended not using contraceptives in future reasoning its side effects. Women welling NGO clinic for obtaining contraceptives commodities. Majority used Pill for spacing their births. Husbands was the preferred group about making decision for birth spacing.
Conclusion and Recommendation: Awareness does not always lead to the use of contraceptives. A lot of educational and motivational activities and improvement in Family planning services are needed to promote the use of contraceptives and reduce maternal and child mortality. Men involvement in health care programs design is of utmost importance as they mostly influence decision making at the household level which resulted in active male participation and community ownership.
Acknowledgements: I, the author of the paper would like to express my sincere gratitude to my professors at Jodhpur Scholl of Public

Corresponding Author:- Noor Hassan Shirzad.
Address:- Jodhpur School of Public Health (JSPH). Maulana Azad University, Jodhpur, India.

Health (JSPH), Maulana Azad University, Dr. Latika Nath Sinha, Dr. Nitin Joshi, Dr. Parmila Vivek, who taught me how to conduct a research and provided me with valuable comments on my work. Besides I gratefully acknowledge the contribution of Dr. Naseer Ahmad Durrani Family Planning Services Integration Advisor, Jhpiego/ AFGGO, Kabul., Afghanistan and my co-guide and facilitator. I also would like to thank survey team (Supervisors, Data collectors and Data entry officers) who participated in this work, also District health officers for their thorough support during survey and finally would like to thank all staff of Kart-e-lagan and Nadali CHCs for their well arrangement of client's flow and proper accommodation for survey team.
I hope this research will contribute to enhancement of quality of health services delivery in Afghanistan.

……

Rational/ Background:-

Health needs in Afghanistan continue to be enormous as the country seeks stability, attempts to develop its infrastructure, accelerate the education of its people and raise their standard of living all at the same time. Nevertheless, in less than two decade of effort, significant improvements have been made in the health status of the population and the strengthening of its Health system.

Despite ongoing support to health activities, maternal mortality rates (1291 per 100,000 live births), infant mortality rates (45 per 1,000 live births), AFDHS 2015, and under 5 mortality rates (55 per 1,000 live births) AFDHS 2015 continue to remain high. High levels of chronic and seasonal malnutrition and wide spread prevalence of infectious disease contribute significantly to these levels of morbidity and mortality.

The fertility rate (FR) is 5.3 in Afghanistan, one of the highest in Asia, Population is now growing by almost 1 million people annually. Because of relatively high fertility in the past, nearly half of Afghanistan's population (47 percent) is under 15 years, and 16 percent is under age 5 years. The number of women who receive antenatal care and give birth in a well –equipped facility in the presence of trained attendant is still low (48% and 18% respectively). In 2015, 50.5% of pregnant women received at least one antenatal care visit from a doctor, nurse, or midwife. At the same time 51% of the births in Afghanistan were at home. A lack of trained female health workers has been cited as the major barrier to reducing the maternal mortality rate, as well as making improvements in other reproductive health issues, as a result of cultural practices, security restriction, and lack of health system capacity limit access of women to the health services; resulting low usage level of birth spacing technology and in adequate information contribute to the problem. This survey aimed to clarify the KAP of Family Planning among married women in Helmand, and explore issue about, access, decision making and attitude toward contraception.

About 200 million women in the reproductive age group in under developing countries, who are not interested in having any more children and want birth spacing, are not using contraceptives. They have Unmet Need for spacing their births, Unmet Need does not necessarily mean the FP services are not available. It may also mean that women lack information regarding the availability of the services, not has sufficient inspiration for FP; To be away to achieve the fifth goal of Millennium Development Goals (MDGs) it is considered the key to reduce the Unmet Need for FP and improve New-born and Child Health services.

Unmet Need:-

Basically women's who are in the reproductive age group (15-49 years) and are sexually active would prefer to use FP methods for avoiding unwanted pregnancy but are unable to or not using any method of contraception, are considered to have an " Unmet Need" for FP. This concept highlights towards the existing gaps between reproductive intensions of the women's and their current behavior regarding the use of contraceptive. This standard formula also includes all fecund women who are married, living in union and sexually active, wants spacing (Want to postpone their next birth for at least two more years) or limiting (who either do not want to have any more children) the birth of child but are not using any methods of FP. The unmet Need group also includes all pregnant married women whose pregnancies are mistimed or unwanted.

The general concept of unmet need was first introduced in the 1960s, when researchers began to demonstrate and measure the discordance between women's desires to limit their births and their actual use of contraception in much of the developing world. The gaps between knowledge, attitudes and practice- the "KAP- gap" – were measured in national surveys undertaken in developing countries from the 1960s through the early 1980s.

Literature Review:-

The reproductive Health component is one of the core components of Afghanistan Health system where it contributes to the reduction of maternal mortality and morbidity in Afghanistan.

National Reproductive Health Policy (2006-2009) was known to be one of the key documents of the Ministry of Public Health and was made possible by the Ministry of Public Health with technical efforts of the entire health partners including donor agencies, UN and NGOs. So, as to cover other areas connected to Reproductive Health and satisfy current needs, this policy got revised and implemented for year 2012 to 2016.

Based on the revised policy, all Afghan families have the right to have access to the highest Reproductive health standards. Reflecting the steady commitments of the Ministry of Public Health and its partners, this policy aims at providing needed opportunities so as to enable all Afghan families to have access to quality reproductive health services.

The four main priorities of the National Reproductive Health Policy include;

- Maternal & Child Health.
- Family Planning/ Birth spacing
- Sexually transmitted Infections (STI)
- And Breast and Cervical Cancer

With respect to the mechanisms of service delivery, Family Planning methods divided in to two categories in Afghanistan; those that are universally available and those that are available in specific circumstances or selective available. Universal available means that BS/ FP variety of methods available at all levels of the health system (Health Post, BHC, CHC, DH and PH as in the commercial sector from trained pharmacists) and counseling on natural and traditional Family planning methods. The Basic Package of Public Health (BPHS) provides clear direction regarding availability of these methods from trained providers, all community health workers, nurses, community Midwives, and doctors should be trained on counseling skills and safely and competently provide these FP methods. As well, Doctors and Midwives should be able to manage complications and side effects of these methods.

CHWs currently authorized and trained to provide the first and repeated dose of injectable and oral contraceptives.
Other methods Intra Uterine Contraceptive Devices (IUCDs) and surgical methods of contraception (Vasectomy and Tubal ligation) are selectively available under special scheme.

Emergency contraception refers to back- up methods for contraceptive emergencies which women can use with in the first few days after un- protected intercourse to prevent an unwanted pregnancy.

End Poverty and Hunger:-

Per capita gross national product has a correlation with the prevalence of modern contraceptive methods, and Family Planning reduces the aggregate demand for increasingly scarce food products. Better birth spacing reduces incidence of low birth weight and poor maternal nutrition. Family planning results and more wealth and less hunger, stated in SDGs.

Gender equality:-

Unplanned pregnancies devote women from other life plans. In Egypt, women who use contraception are more likely to be employed than nonusers. In Brazil and Indonesia, use of long- acting or permanent contraceptive methods was associated with greater likelihood of working for pay. Using Family planning empowers women; involving men in Family planning can lead to changes in gender norms. Empowering women in many ways,

including their ability to achieve their desired family size, is the most important driver of modern development efforts, stated in MDG3.

Child Health:-
About 1.4 million infant deaths are averted globally each year by preventing an intended pregnancy. If we could meet all demands for contraception, another 1.1 million infant deaths would be prevented. Family planning increases child survival.

Maternal Health:-
Universal access to reproductive health, including Family planning, is designated in MDG 5B. Also, if a woman seeks to terminate an unintended pregnancy, the risks associated with unsafe abortion are among the main causes of maternal death, especially in young women. If she wishes to continue the pregnancy, in low- resource settings without safe delivery services, and risks of maternal mortality and serious complications are also high.

A combination of factors like non– availability of services, baseless traditional beliefs and misconception play a big role, a fairly large number of the population believes the use of artificial contraceptives for Family planning is against nature and also against Islam. Family planning in Iran, a neighboring Islamic republic, Pakistan's Family planning programs has failed in recent years due to neglect and constant policy changes as a result of political upheaval. 96% of married women were reported to know about at least one method of contraception, only half of them had ever used it "Stated by Dr. Ansar Ali Khan an advisor of reproductive health to the united Nations Population Fund (UNFPA) in Pakistan".

The UNFPA states about contraception
The use of modern methods of contraception is an important basis for the long term health of adolescent girls. Contraceptives prevent unintended pregnancies, reduce the number of abortion, and lower the incidence of death and disability related to complications of pregnancy and child birth. If all women with unmet need for contraceptives were able to use modern methods, an additional 24 million abortions (14 million of which would be unsafe), 6 million miscarriages, 70,000 maternal deaths and 500,000 infant deaths would be prevented.

The WHO states about maternal health
"Maternal health refers to the health of women during pregnancy, child birth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women its associated with suffering, ill-health and even death."

Closely spaced pregnancies with in the first year postpartum are associated with higher risks of preterm births, as well as infants who are low birth weight or small for gestational age. If spacing between pregnancies were increased to 24 months, maternal and under 5 mortalities would decrease by 30% and 13% respectively. Evidence suggest that women who have more than 4 children are at increased risk of maternal mortality.

Promotion of Family planning- and ensuring access to prepared contraceptive methods for women and couples- is essential to securing the well- being and autonomy of women, while supporting the health and development of communities.

Despite the fact that contraceptive usage has increased over a period of time, there exists a Knowledge Attitude and Practice- gap regarding contraception (Malek- Afzali, 1998; Ramesh *et al.*, 1996) the reason for not using any family planning methods are lack of knowledge and education, religious belief and fear of side effects. family planning has two main objectives; firstly, to have only the desired number of children and secondly, proper spacing of pregnancies (Mao, 1999).

Asia contains 61 million married women with unmet need, or 58% of the total for the developing world, reflecting the inclusion of several countries with very large populations (India, Indonesia, Pakistan and Bangladesh). Sub-Saharan Africa contains 24 million (22% of the total), mostly because of the large populations of Nigeria, Ethiopia, South Africa and the Democratic Republic of the Congo. Latin America contributes 11 million married women with unmet need (11%), nearly half of whom live in Mexico and Brazil. North Africa and the Middle East account for only about eight million (8%), and the Central Asian republics, with their smaller populations, have a total of 1.1 million (1%).

In the developing world as a whole, the prevalence of unmet need among married women is about equally accounted for by women who wish to space and those who wish to limit the births, but important variations exist. In Sub-Saharan Africa, 65% of unmet need is for spacing; in Latin America by contrast, only 42% is (not shown). In Asia, spacing and limiting need are nearly equal. Such differences call for different kinds of contraceptive supplies and different budgetary considerations (GUTTMATCHER INSTITUTE, Journal on, International perspective on sexual and reproductive health).

Objective:-

The major objective of this study was to estimate the knowledge, attitude and prevalence of contraception methods among reproductive age women in Helmand.

Specific objective:-

- To identify gaps between knowledge and practice among women of reproductive age (15-49).
- Explore access to contraception services and main source women use for obtaining contraceptive commodities.
- To determine more influential groups contributes FP decision making.

Study design:-

A Cross- sectional survey conducted in out- patient departments of, Nadali and Kart-e-lagan Comprehensive Health Centers (CHCs) located in two different districts of Helmand province. A Simple Random Sampling (SRS) method was used. Helmand province comprise of 14 districts shown in *Table 1* below;

Table 1:- Districts of Helmand province

S/n	District name	Population as per CSO
1	Baghran	90740
2	Kajaki	73800
3	Mosa Qala	70218
4	Nahre-saraj	116600
5	Nowzad	58800
6	Sangin	74500
7	Washir	24000
8	Lashkar Gah	85600
9	Desho	18000
10	Gramseer	99500
11	Khanesheen	31500
12	Nadali	61400
13	Nawa	84900
14	Marja	45000

Stage I: Selection of District:-

For selection of district Simple Random Sampling (SRS) was performed, two districts were selected as a primary sample frame, shown in *table 2* below;

Table 2:- Selected district

S/n	District	Cod#	Population as per CSO
1	Nadali	2301	61400
2	Lashkar Gah	2308	85400

Stage 2:- Selection of Health facility:-

Total of 11 health facilities exists in selected district including CHC, BHC and SHC shown in table 3 below;

Table 3:- Health facilities of selected district

S/n	Health facility	Type of HF	Code #	Population	District
	Nadali	CHC	699	28100	Nadali
	Naqil Abad	SHC	2441	8200	Nadali

	Chahe- anjir	BHC	1853	12500	Nadali
	Sayed Abad	BHC	1854	12600	Nadali
	Babajee	SHC	2446	5000	Lashkar Gah
	IDP- Mukhtar	CHC	1850	19600	Lashkar Gah
	IDP- Mukhtar	BHC	1861	8000	Lashkar Gah
	Kart-e-lagan	CHC	1790	32500	Lashkar Gah
	Khoshkaba	BHC	1849	10500	Lashkar Gah
	Qala-e-Bost	SHC	2445	6000	Lashkar Gah
	Safyan	SHC	2444	4000	Lashkar Gah

For selection of the health facility a probability proportion to size applied. Nadali CHC in Nadali district and Kart-e-lagan CHC in Lashkar Gah selected as last sampling unite, mentioned in *table 3* above.

A total of 384 women enrolled in the study using convenient sampling method. A convenient sampling method was used to select the study participants, because the application any of the probability sampling methods would have obstructed the flow of service in the clinic and drastically increase client's waiting time. To start the survey a verbal consent has taken prior, than pre- interventional assessment was done using the structured questionnaire measuring the respondent's knowledge and attitude regarding Family planning written in Pashtu. The questionnaire took about 20 minutes to be completed. Women were informed of the purpose of the study and it was emphasized that the study was an attempt to improve knowledge and attitude about Family planning and contraception methods. Permission to carry out the study was obtained from District Health Officer (DHO) and health facility authorities. The questionnaires were assigned unique codes and the result of each individual questionnaire were kept in strict confidence.

Sample Size:-

In a view of the design of the study a purposive or non- probability convenient sample was selected. A sample size determination technique on the basis of pre assigned confidence level (95% confidence level) and margin of error (5% margin of error) was used. A sample of 384 married women selected for interview attending outpatient department of Nadali and Kart-e-lagan clinics.

Inclusion Criteria:-

- Married women with reproductive age (15-49) visiting health facility.

Exclusion criteria:-

- Women with emergency with referral indication
- Married women not experienced their first pregnancy since three years of marriage.
- Women forced by their relative and not welling by herself to participate.

Duration of the study:-

Table 4

Study work plan

No	Activities	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
1	Drafting of research proposal	X	X																																				
2	Translation of reasearch tools(Questionaire & consent form)	X	X																																				
3	Proposal submission for JSPH approval			X	X	X	X	X	X	X	X	X	X	X	X	X	X																						
4	Hiring of data collectors																	X																				
5	Training of data collector																		X																			
6	Pretestin and finalization of research tools																			X	X	X																
7	data collection																						X	X	X													
8	Data entry																									X	X	X	X	X								
9	Data cleaning and editing																														X	X						
10	Data analysis																																X	X				
11	Drafting final report																																		X	X	X	X	X
	Month and year	Jul-16			Aug-16				Sep-16				Oct-16					Nov-16				Dec-16			Jan-17				Feb-17			Mar-17				Apr-17		

Research Methodology:-

A total of 384 women enrolled in the study using convenience sampling method. A convenience sampling method was used to select the study participants, because the application of the probability sampling methods would have obstructed the flow of service in the clinic and drastically increase client's waiting time. Prior to survey a verbal consent was taken for their approval on coming steps, every target woman interviewed in a separate room with strict privacy.

A structured questionnaire *(Annex I)* was used for interview of target respondents; the questionnaire was designated in two sections; the first section covered the socio-economic background of the respondents and the second section inquired into the KAP of Family planning. in order to avoid bias, Simple Random Sampling (SRS) was used in the survey because it ensure that each respondents have equal chance to be selected.

Study Tool:-

A structured questionnaire *(Annex1- Questionnaire)* was used for interview of target respondents; as mentioned before the questionnaire comprise of two section, socio- economic section and section inquire KAP of Family planning.

Pilot testing and Data collection:-

The questionnaire was developed in English and was translated in to the national language Pashtu after pretesting in order to accommodate professional and cultural validation. The pre- test emphasized to improve the translation, check accuracy and adequacy of the questionnaire, and to know the time for the interview of each questionnaire. 10 Midwives who already familiar with Family planning programs enrolled as survivor and provided with three days training on questionnaire and data collection process. In addition, in order to ensure researcher knowledge on survey procedure and use of survey tools a pilot testing also performed in the health facility, weak points identified and further improved. Data collection took a period of three weeks in both target health facilities, after completion of data collection process an excel data base is developed and all data from the questionnaire was entered.

Data Analysis:-

Data of the filled questionnaire entered in to excel base software and further edited and cleaned by head of research team. To minimize keypunch errors and ensure quality of data double data entry mechanism used for each questionnaire. The data then further analyzed.

Ethical consideration:-
Women were informed of the purpose of the study and their right to refuse to answer any question of the questionnaire. It was emphasized that the study was an attempt to improve knowledge and attitude about Family planning and contraception methods, they further assured that their name or any identification leading to them will be kept strict confidential and will not be appear in any report or publication resulting from this study. Permission to carry out the study was obtained from District Health Officer (DHO) and Health facility in –charge. Questionnaire were assigned unique codes and the results of each individual questionnaire were kept confidential. Informed consent note in written *(Annex II- consent form)* were taken from each respondent during the interview and data collection.

Limitation of the Study:-
- Budget limitation is an issue for expansion the study to all health facilities of the province, so that represent the whole province.
- Data collection process monitored during interview in outpatient department of health facility, security constraint and cultural issues prevented to re- check data in the field.

Result and Key findings:-
Demographic characteristics of respondents:
A total number of 384 married women age from 15-49 years old were interviewed. The highest percentage of respondents was women in the age group of 30- 34 which accounted for 31% of respondents. The lowest percentage of respondents accounted for women in interval of 15-19 and 45-49 age groups are almost 4%. Respondents Mean age was 32 years old.

About 37% of respondents had one to four children in their family. Almost 35% of respondents had four to five children, 24% of respondents had more than five children in their family. And 4% of women had not children.

About 86% of respondents had received no schooling, 13% of respondents had enrolled in primary, secondary and high school respectively. Only 1% of respondents had entered university.

Knowledge of contraceptive (Methods, source of information and source of services):
In this study, the knowledge of contraceptives refers to the number of contraceptive methods known, source of information for family planning known, and the source of Family planning known by respondents. The respondents were asked whether they had heard about contraceptives, and what contraceptive methods they were used. The types of reported methods were then tick in the questionnaire. In addition, questions were asked regarding the source of information and place they obtained their recent contraceptive method.

The result show that 92% of women heard about contraception, the study also found that information about Family planning was mostly obtained through healthcare staff (63%), followed by Husband (12.19%), Friends (7.11%), Mass Media (6.56%), Family members (5.96%), and then via Community Health Worker (CHW) and Religious leader (1.14% each), the other sources counted for (3.30%) on family planning information. See *table 5* below;

Table 5:- Source for obtaining Family planning information known by respondents

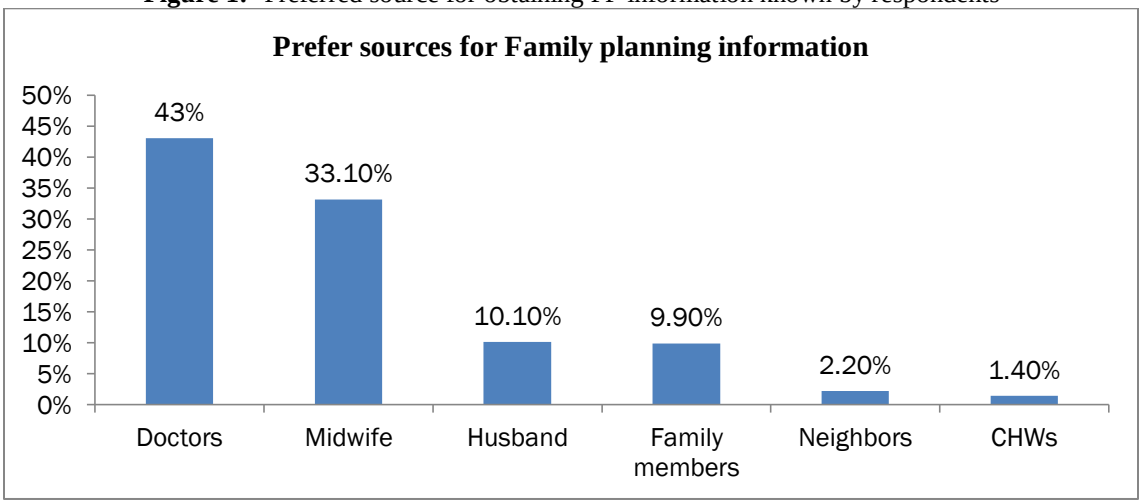
Source	% heard about Family planning
Health care provider	222 (62.5%)
Husband	43 (12.19%)
Friend	25 (7.11%)
Mass media	23 (6.56%)
Family member	21(5.96%)
Community Health Worker	4 (1.14%)
Religious leader	4 (1.14%)
Other	12 (3.30%)

Attitude toward addressing Family Planning:
It is noticeable that respondents showed a positive attitude toward Family planning. To know about importance of contraception the respondents were asked "How do you rank role of FP for mother and child health" Near to half of

the respondents (44%) stated that Family planning is VERY IMPORTANT for maternal and child health, and 35.5% respondents said that FP is IMPORTANT for maternal and child wellbeing, (15%) women believed FP have no role or not important, and 17.5% were column with no response.

The result indicates that women preferred to discuss Family planning with Healthcare providers, Husbands, Family members and Neighbors. In our sample Community Health Worker were the least popular group from which respondents sought family planning information. It was noted that women often talked about Family Planning information with healthcare providers, Husbands as well as Family members and neighbors. *Figure 1* represent preferred sources for Family planning counseling;

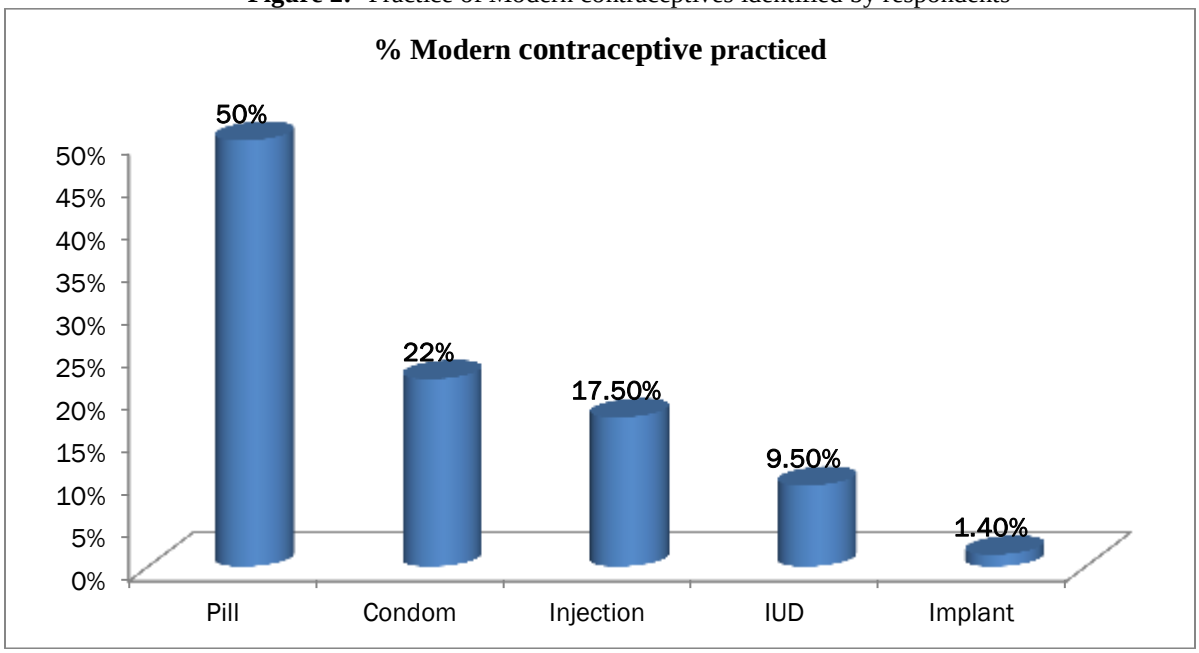
Figure 1:- Preferred source for obtaining FP information known by respondents



Practice of Family planning:-

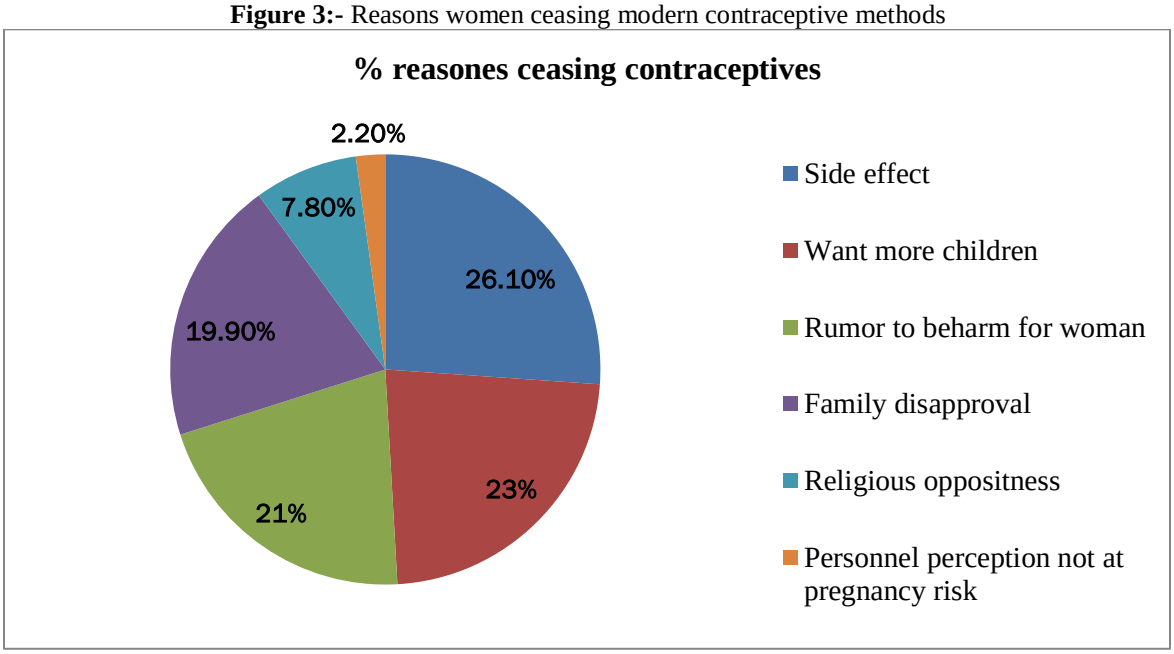
About 58% of respondents had previously used some modern contraceptive methods. And 20.9% of respondents were using contraception at the time of the study. Among the current users, the majority were Pill users (50%); secondly condom (22%); followed by contraceptive injection (17.5%), IUD (9.5%), Implant was use by less than 1.4%. Figure 2 describes percentage of method practiced by respondents.

Figure 2:- Practice of Modern contraceptives identified by respondents



Among all respondents, 58% were using some method of modern contraceptives and 42% were not practicing any methods. Among the respondents 27.4% were did not intend to use contraception in the future. The main reason being fear of side effects (26.1%), desire for more children (23%), Rumors to be harm for their health in future (21%), Family disapproval (19.9%), Religious oppositeness (7.8%) and Finally personal perceptions among respondents that the women themselves were not at risk of pregnancy (2.2%). *Figure 3* shows reasons for ceasing method.

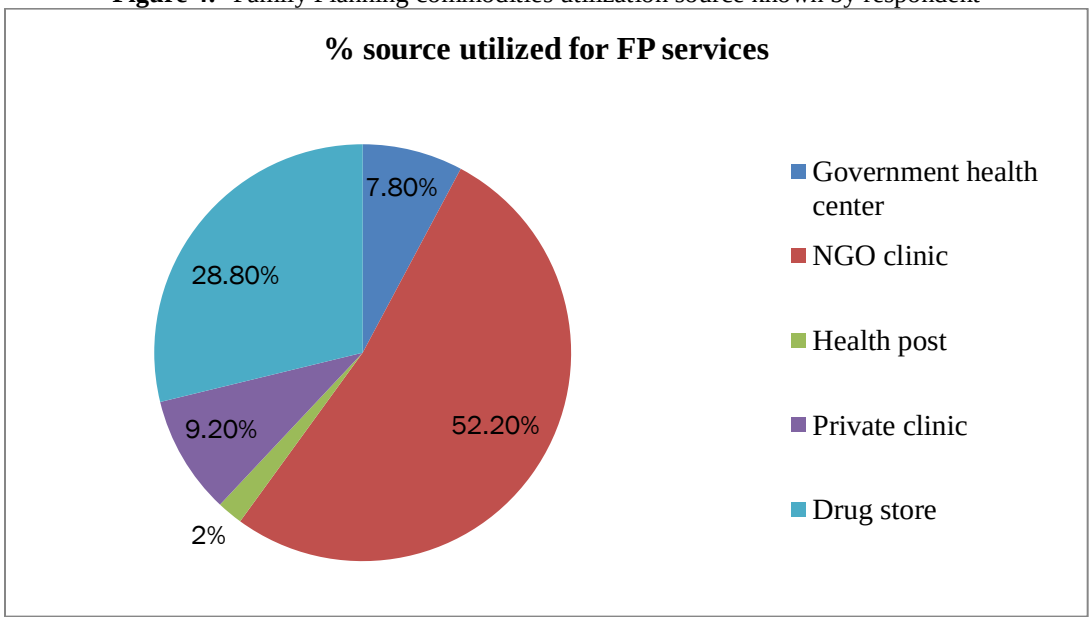
Figure 3:- Reasons women ceasing modern contraceptive methods



Family planning utilization sources:-

To obtain information about source of Family planning utilization the respondents were asked "Where you obtained your most recent/ current FP method?". Results shows that more than half of the respondents (52.2%) mentioned NGO clinic, Drug store and Private clinic were in second and third step, Government hospitals and Health Posts were less than 10% for utilization of contraception services. see *Figure 4* below:

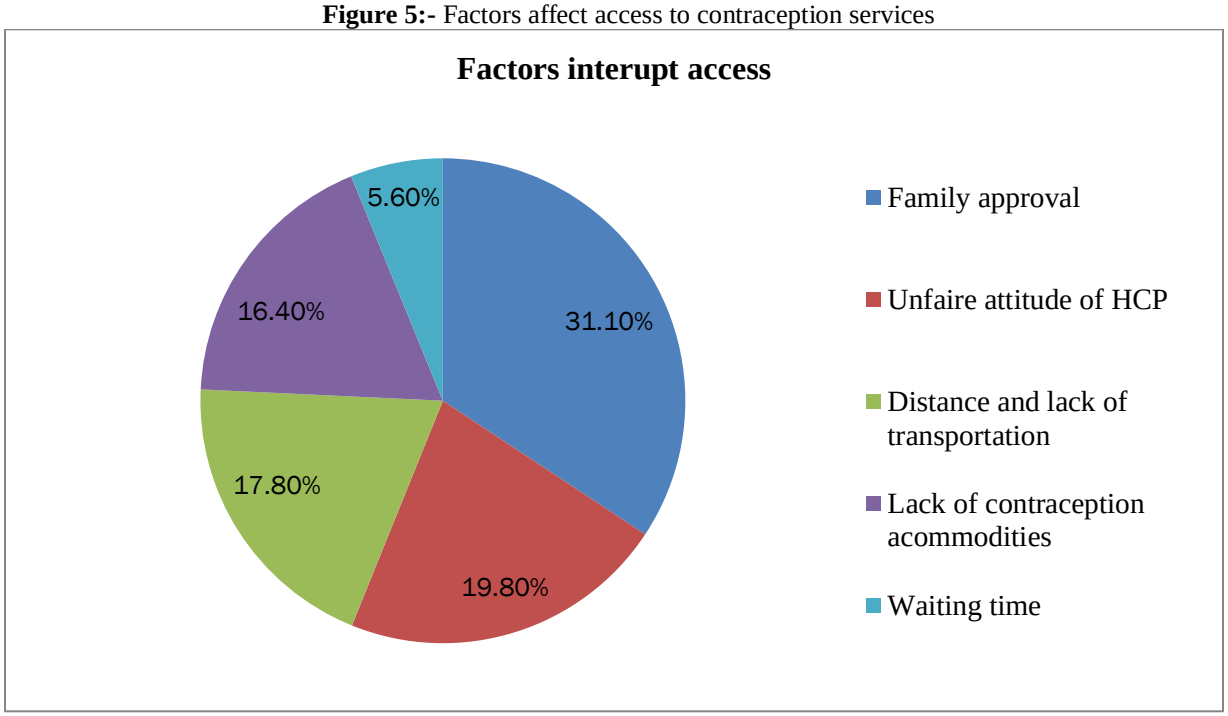
Figure 4:- Family Planning commodities utilization source known by respondent



Access to Family Planning services:-

About 85.2% of respondents had access to contraception services in past 12 months, 14.8% of women have desire to adapt contraception but not practicing any method, the study result revealed that most of the women (31.1%) have no family and relative's approval for obtaining contraception services, waiting time in Health center for receiving contraception services counted as least affecting factor for access. *Figure 5* below represent issues on access to FP services.

Figure 5:- Factors affect access to contraception services



The study also declared that almost 57% of respondents reported that their husbands have influence on their decision for seeking birth spacing methods, followed by family members and mother/father in-lows respectively, religious leaders, friends and healthcare providers not exceed than (5%). Among respondents (11.3%) of women are independent in their decision. *Table 6* below shows influential groups with their percentages.

Table 6:- Group's percentage influence women decision on contraception

Group	% Influence women decision
Husbands	201 (57%)
Independent	40 (11.3%)
Family members	23 (6.5%)
Parents	18 (5%)
Mother/father in- law	16 (4.6%)
Religious leader	7 (2%)
Friends	5 (1.4%)
Health provider	4 (1.1%)
Independent (themselves)	39 (11.1%)
	(100%)

Discussion:-

Knowledge of any modern contraceptive method among respondents was 92%. The Afghanistan Demographic & Health Survey 2015 also showed almost similar result that 95% of married women heard about Family Planning method.

The main source for obtaining Family planning information is Healthcare provider (63%). Respondent's preference Doctor and Midwife for counseling regarding Family planning, both doctors and midwives counted for 76.10%.

From respondents 58% were ever used any modern method of contraception. Currently 20.9% of respondents reported that they use any modern method. Among the respondent's majority were Pill users (50%). AFDHS 2015 show almost the same data and reported 20% women as current user of modern methods.

The study shows that 14.8% of women have unmet need for Family planning. Unmet Need in AFDHS 2015 was high (25%) than that found in our study. The dominant result for not using contraceptive being fear of side effects of modern methods. Due to some reason 27.4% of women in the study intend not using contraceptive in the future.

Now women have positive attitude toward Family planning and they now better understand the relationship between Family planning and their own health as well as their children health. The study also highlights that Husbands are mostly involving in decision making for practicing Family planning methods, it is the most important issue for women living in cultural and religious community like Helmand. The same picture mentioned in a study "KAP study among married men and women in rural areas of Pakistan" conducted in June-2015 stated; it is interesting to note that stringent restrictions on female mobility emerged as a major barrier across the regions. Females are not allowed to step out alone without the permission of their husbands or mothers- in-low. Women going alone even for medical help are thought to bring dishonor to the family.

Nevertheless, the study findings need to be treated cautiously to avoid over generalization due to some limitations mainly arising from the study design. First of all, this a qualitative study and is conducted with a limited number of people and may not represent the views of the whole population in the said community. Secondly the study documented the opinions of women in outpatient department of health facility; most of them living at the vicinity of health facility, therefore the opinions may vary from the opinion of women with different socio-economic characteristic.

Conclusion/ Recommendation:-

Regardless of socio-economic status, respondents had high knowledge of, and a positive attitude towards, Family planning. More than half of the respondents were practicing some modern methods. Healthcare providers are the main source for Family planning information, and also preferred for counseling of Family planning. NGO clinics are the most popular place for obtaining contraceptive commodities. Side effect were the biggest concern for both current users and non-users. Rumors about possible side effects deterred some women from using modern contraception. The Government and NGO should deliver extensive contraception counseling services, in which first time contraceptive users can receive follow up consultations where any concerns about side effects can be discussed and alternative options explored.

Furthermore, Family planning and birth spacing interventions need to focus alleviating fears about side- effect among users through effective counseling and providing adequate information to both men and women about method- related side- effects and how to manage them. In addition, involving community leaders, community health workers, Religious clerics, health workers, and social media in awareness raising campaign can help address socio-cultural and religious concerns.

Moreover, the study also identified strong need for involving men in healthcare program design to improve women's and newborn's health as they mostly influence decision- making at the household level and this will also result in active male participation and community ownership. Encouraging communication between wife and husband about Family planning and birth spacing should also be part of such campaigns to promote mutual decision- making between wife and husband and make husbands responsible partners in Family planning/ birth spacing decisions and ease the burden of decision- making on women.

References:-

1. Afghanistan Demographic and Health survey 2015.
2. Afghanistan National Reproductive Health Strategy 2010- 2015
3. Afghanistan National Reproductive Health Policy 2012-2016

4. Cates W, Karim Q, El-Sadr A, Haffner WM, Kalema-Zikusoka DWG, et al. (2010) Family planning and the millennium development goals. Science329: 1603.
5. Contraceptive knowledge attitude and practice (KAP) survey. The Journal of Obstetrics and Gynecology of India (J Obstet Gynecol India Vol. 55, No. 6 : November/December 2005 Pg 546-550)
6. BDHS (2011) Bangladesh Demographic and Health Survey, 2011.
7. Hussain R, Bankole A, Singh S (2007) Women with an unmet need for contraception in developing countries and their reasons for not using a method. Alan Guttmacher Institute.
8. Ross JA, Winfrey WL (2002) Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate. International Family PlanningPerspectives 28: 3.
9. Afghanistan DHS surveys 2013. No.96 (the effect of birth intervals on causes of under-five mortality in Afghanistan) ANPHA, MoPH, Afghanistan.
10. Zafar S, Shaikh BT (2014) Only systems thinking can improve family planning program in Pakistan': A descriptive qualitative study. International journal of health policy and management3: 393.
11. Casterline JB, Sinding SW (2000) Unmet Need for Family Planning in Developing Countries and Implications for Population Policy. Population and Development Review 26: 4 691–723.
12. Riyami A, Afifi M, Mabry RM (2004) Women's autonomy, education and employment in Oman and their influence on contraceptive use. Reproductive health matters12: 144-154.
13. Knowledge, Attitude & Practice (KAP) Baseline Study Afghanistan, 2007
14. COMPRI- A project, CONSTELLA- future/ USAID (Nov, 10, 2007)
15. Knowledge, Attitudes and Practices (KAP) Survey related to Family Planning and Reproductive Health- Jordan. KAP Dissemination Event (September 30th, 2015)
16. Knowledge, Attitudes and Practices of Contraception among Afghan Refugee Women in Pakistan (A Cross-Sectional Study) (Published: November 2, 2012)
    http://dx.doi.org/10.1371/journal.pone.0048760
17. Revitalizing Postpartum Family Planning Services in India (Fact Sheet: April 2015)
18. Ministry of Health and Family Welfare (MoHFW), Government of India, Multiple State Governments (Oct-2009 – present)
19. Sharan M, Valente TW (2002) Spousal communication and family planning adoption: effects of a radio drama serial in Nepal. International Family Planning Perspectives 16-25.
20. Koblinsky M, Anwar I, Mridha MK, Chowdhury ME, Botlero R (2008) Reducing maternal mortality and improving maternal health: Bangladesh and MDG 5. Journal of health, population, and nutrition26: 280.
21. Knowledge, Attitude and Practice (KAP) of Family Planning among Married Women Banteay Meanchey, Cambodia Vong SREYTOUCH1 Graduate Student, Ritsumeikan Asia Pacifi c University.
22. Revitalizing Postpartum Family Planning Services in India (Fact Sheet: April 2015)
23. Ministry of Health and Family Welfare (MoHFW), Government of India, Multiple State Governments (Oct-2009 – present)
24. Islam R, Islam AZ, Rahman M (2013) Unmet Need for Family Planning: Experience from Urban and Rural Areas in Bangladesh. Public Health Research3: 37-42.
25. A Study on Knowledge, Attitude, Practice and Quality of Care in Family Planning at Dessie Zuria District (Journal Home > Vol 3, No 2 (2001) http://dx.doi.org/10.4314/jemp.v3i2.10600

Annexes:
Annex1: Questionnaire
Annex2: Consent form