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Community Systems Strengthening in Afghanistan: a way to reduce domestic violence and to reinforce women's agency

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In Afghanistan, a burden of poor mental health exists within the contexts of ongoing poverty, social inequality, and persistent violence. Although women in Afghanistan share the same problems as most women in developing countries, many elements of the inequalities that Afghan women experience are extreme, and the context in which these women live is exceptional. Addressing these contextual factors, in order to discover culturally acceptable and feasible solutions to these problems, poses major challenges and asks for a multi-sectoral approach. In 2002, HealthNet TPO began to implement mental health activities in the Nangarhar province. An important objective of the programme's activities has been the development of community based, psychosocial interventions to enhance the population's capacity to deal with the consequences of mental distress. During the programme implementation in Afghanistan, it became evident that, in order to reduce mental distress, the social determinants of (mental) health required more attention. This paper describes how a specific programme to reduce domestic violence, and to reinforce women's agency within the context of the present day challenges, is being implemented according to a community systems strengthening framework that has been adapted for this purpose and context.

Keywords: Afghanistan, community systems, domestic violence, women's empowerment

Background: the position of women in present day Afghanistan

Afghanistan has suffered through more than three decades of armed conflict, and remains one of the least advanced countries in terms of human development indicators (United Nations Development Program (UNDP), 2009). Although the exact burden of mental health issues is unknown, studies point to disproportionately high levels of anxiety and depression among women. This may, to a large extent, represent high levels of *distress,* rather than true mental *disorders* (Bolton & Betancourt, 2004; Miller et al., 2006, 2008). High levels of anxiety symptoms, depression symptoms and exposure to traumatic events are also evident among children (Catani Schauer & Neuner, 2008; Panter-Brick et al., 2011). Substance use, in particular addiction to opium, is also common and on the rise, particularly in poppy abundant areas. Furthermore, social factors, such as poverty, illiteracy, poor education, high rates of family violence, gender inequalities and reproductive health problems are all risk factors in terms of mental health (WHO, 2009a; 2009b).

Many problems in present day Afghanistan are related to the poor economic situation, which is reinforced by ongoing war and

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insecurity. Traditional beliefs and customs, high illiteracy rates, which includes no precise knowledge of Human and/or Islamic Rights (HealthNet TPO, 2010), are all parts of a social environment where family violence and other harmful practices have a high prevalence, and continue to date. The ongoing war has negatively affected the social fabric of life; traditional tribal leadership has diminished, tribal violence has increased (Edwards, 2009), marriage practices, such as selling or exchanging girls, are abused for monetary gain (Aziz, 2012), and the use of drugs (opium and hashish) is widespread.

Women are suffering primarily from violence within forced marriages, where unfair cultural practices like the exchange of girls (*badal*) to avoid dowry costs, strengthen family relations, or resolve conflict are common practices (Smith, 2009a). The loneliness experienced by many women is exacerbated while living with their husbands' families, and being separated from their own. Additionally, the authority to punish a woman verbally, physically or emotionally often extends to others than just the woman's husband. Mothers-in-law are often perceived to be important perpetrators of violence against their daughters-in-law (HealthNet TPO, 2011). Some of the harmful practices, like selling or exchanging girls to settle debts, asking for high bride prices or denying widows' inheritance rights, are acts that most Afghans do not view as an extension of their culture, but as a reflection of the breakdown of customary trust and mutual support, and therefore a manifestation of hardship and lack of rule of law as a result of decades of conflict (United Nations Assistance Mission in Afghanistan (UNAMA), 2010).

Since 2001, Afghan women and girls have taken great personal risks to renegotiate the strict gender roles and identities that were imposed upon them by the Taliban. In the face of rising insecurity, violence, and threats, they have made use of opportunities to go to school and university, to earn a living, and to participate in public life. Their progress has nonetheless been slow. The cultural barriers that exist to women's participation in the public sphere remain deeply rooted. Growing anger over the prolonged international military presence and the regarded *'pro-women agenda'* of the west has generated a backlash towards girls and women with any perceived association with western interests (Cortright & Persinger, 2010).

During the last few years, the state building exercise within Afghanistan has mainly been driven through seeking to transplant western institutional arrangements into Afghanistan (Larson, 2011). The underlying assumption was that by creating an open environment of political and economic competition, governed by the rule of law and impersonal relations, the benefits the west has gained from these institutional arrangements would quickly filter through to Afghanistan as well. However, this transformation process has failed. This is due, in large part, because Afghanistan is not adrift in complete disorder, as has been assumed, but operates based on its own logic. What governs political and economic relations in Afghanistan is not open competition, but deeply personalised relationships (Kantor & Pain, 2010a). Intertwined with these factors are fundamental Islamic values linked to moral obligations, including the division of the roles between men and women.

According to the many reports over the occurrence of domestic violence in present day Afghanistan, the personal opinions of individuals are often more egalitarian and forward looking than the cultural norms

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and practices of the communities[1] in which these individuals live (Smith, 2009a). However, alternatives to dominant practices, or ways of breaking with harmful traditions, are still rarely suggested or acted on. This finding could be analysed against the background of Afghan culture. One of the fundamental paradigms in the Afghan worldview is *'honour and shame'*. Honour, in the context of Afghanistan, means publically complying with moral codes, social norms and the essential interests of the group. A group can be defined as cultural, ethnic or religious in nature. The desire to avoid social disgrace and shame provides a strong incentive for individuals to comply with these expectations, both in private and in public life. Honour killings, for example, recognise a man's so-called *'right to kill a woman'* with impunity, because of the *'damage that her immoral actions'* have caused to the family honour (UNAMA, 2010). Honour and shame are the centrepieces of Afghan self-definition, and as a result they strongly influence the behaviour of both individuals and groups (Latif, 2011). People will not change customs or practices, if their neighbours continue their pre-existing habits, and if these changes are imposed upon them, especially by foreigners unfamiliar with Islamic traditions and customs. However, as family is of the utmost importance in the Afghan culture, Afghans are also sensitive when it comes to the physical and mental wellbeing of their families. Changing customs and habits, like early or forced marriages that are often the result of these moral codes and social norms, will only be possible if people are aware of the negative impact certain practices can have on the (mental) health of their family members. The basic question, therefore, is how to mobilise large groups of people to abandon practices that affect entire families and communities.

HealthNet TPO in Afghanistan

HealthNet TPO is a non-profit organisation that works in countries affected by chronic conflict. Established in 1992, its aim is to bridge the gap between emergency aid and structural development. Its mission is to transform emergency health relief into sustainable health development by stimulating and supporting local initiatives. HealthNet TPO started in Afghanistan in 1994 with a disease control programme in refugee camps at the border with Pakistan. The mental health programme, initiated in 2002, provided comprehensive training programmes for health care staff. This has resulted in the integration of mental health within basic health care (Ventevogel et al., 2012). As well as providing policy support for the Ministry of Public Health (MoPH) and implementing basic psychiatry within the health care system of 10 provinces, the organisation provided psychosocial support to people living in various communities over six provinces. Between 2006 and 2010, HealthNet TPO also implemented programmes to reduce domestic violence in several provinces, in close collaboration with the Ministry of Women's affairs (MOWA) and civil society organisations. These experiences lead to the programme *'Reinforcing the ability of Afghan women to undertake culturally appropriate action towards the improvement of their living conditions'*, that is funded through the European Commission (EC). The programme started in 2011, and is expected to end in 2014.

Rationale for using the Community Systems Strengthening (CSS) approach

Social justice is an important determinant of health. It affects the way people live, their consequent chance of illness, and their risk of premature death. Inequities in health arise because of the circumstances in which

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people grow, live, work, and the systems put in place to deal with illness. Political, social and economic forces in turn, shape the conditions in which people live and die. The social determinants of health include income (food), social or cultural connectedness and status, education, employment and working conditions, gender, social support, policy, and legal and governance issues (Commission on Social Determinants of Health, 2008; WHO, 2009a).

To anchor the specific development of community interventions, based on this understanding of social context, HealthNet TPO Afghanistan established a new department in its organisation: the Community Systems Strengthening (CSS) Department. This department develops interventions that are primarily aimed at the social relationships that affect the determinants of health within the community[1]. The goal is to empower people to restore social cohesion/trust. The activities involve a broad range of community actors, enabling them to contribute as equal partners to the long term sustainability of health and psychosocial wellbeing. Activities are also targeted at creating an environment that is responsive and supportive, and where changes can become possible. CSS can have an effect on health without the involvement of formal health care. However, one major focus is on creating the cultural appropriate and necessary preconditions for, among other things, the (re)establishment of a functional health system.

Piloting the CSS framework in Afghanistan

The programme described in this paper aims to promote culturally appropriate solutions to increase the capacity of women to take care of themselves and their children, to reinforce their autonomy and to increase income, while also reducing domestic violence. In order to come to a comprehensive set of actions, the programme adapted the framework for CSS as defined by the Global Fund[2] (Global Fund, 2010). The framework used consists of five major components: (1) mapping communities; (2) building networks of support at different levels; (3) development of an action plan based on identified resources and needs; (4) capacity building of local stakeholders; and (5) specific community activities and service delivery. This paper describes how the programme is currently being implemented according to each of these components. The backbone of the programme consists of women in the 10 participating provinces. In each province, 15 women divided over several districts are trained and mobilised to set up local (sub) groups, in order to generate plans and actions towards an increase in their autonomy. Each woman creates her own network of some 20 members, resulting in approximately 3000 direct beneficiaries.

Component 1. Mapping communities: recognising and working with community preconditions

Experience in the field over the past years has demonstrated the importance of a systematic shaping of a programme's content to the local context. In order to do so, information was needed about major needs, gaps and, even more importantly, relevant (human) resources within specific communities, villages and districts. The collection of relevant information is an ongoing process that can be executed before, during and after more specific actions or interventions. All people living in a community can provide valuable information. The programme uses a checklist where bits and pieces of information are added on a constant basis.

In terms of needs and gaps, people were careful not to disclose their *'secrets'* to people

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who didn't belong to their (extended) family. However, people were more open and willing to share daily issues than commonly expected. Men could be approached in the street, or in the surroundings of a mosque. Women stayed primarily on their compounds, but as has been described for the Pashtun areas in Pakistan, the women in Afghanistan often *'share tales of misfortune'*. Articulating grief, among women, is part of a ritual that serves to establish and maintain relationships (Grima, 1992). Through conversations with the local population, the negative consequences of existing systems within communities (inequality, power imbalances, domestic violence and other harmful practices) could be detected relatively easily.

There is a great diversity of customs and beliefs among the villages and communities in Afghanistan, so even within the same province, practices can vary widely. This can be illustrated by an example of the practice of *'baad'*, where a murder (or accidental killing) is compensated by giving one or two never-married girls in marriage to the victim's family. This practice is not as common now as it was years ago, but still occurs, especially in the more remote areas. In Nangarhar province, this practice has become rare among the Tajik, living in Beshood district. In this part of the province there is less inequality between men and women, probably as a result of the higher educational level. However, in the Shinwar area of the same province, the practice of *baad* is practiced, and girls may be exchanged or sold.

A major objective of the mapping exercises has been the identification of the right entry points and individual and collective mechanisms per community that ensure or hinder the sustainable development of services. In Afghanistan, the significance of social orders where certain families or clans have more power than others should be fully recognised (Kantor & Pain, 2010b). Until local decision makers, like village leaders and elders, are willing to allow more open competition, local social orders have no imperative to change. However, other factors also have to be taken into consideration, such as ethnic background, geographic position, distance from district centres, resource endowment, land distribution, level of education, etc. (Pain & Kantor, 2010).

In the programme, these assessments have been combined with providing information as a first intervention. While assessing needs and exploring the possibilities for women to participate in the programme, women were informed about the benefits of collective action and the importance of mutual support. At the same time, while informing key male figures about the purpose of the programme, they were invited to reflect on their possible contribution to reinforce the overall wellbeing of their families.

Component 2. Building networks of support at different levels

On the basis of the information obtained through the mapping exercises at the beginning of the programme in 2011, context specific changes were defined that guided the setting of objectives and action planning in the following phase. The aim was to create structures where key figures, (local) organisations and governmental institutions could work together, mutually reinforce each other, and thereby have a synergistic and potentiating effect. In Afghanistan, an improvement in wellbeing goes hand-in-hand with reducing poverty and combating illiteracy. As it is not the mandate of HealthNet TPO to work on these issues directly, a multi-agency approach was needed, which required a close coordination

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with stakeholders at all levels, which will be explained below.

At national level The Ministry of Women's Affairs (MoWA) plays a major role. In all provinces where activities are implemented, (networks of) women are directly supported by the Provincial Directorates of Women's Affairs. The Ministry of Public Health (MoPH), with which HealthNet TPO has worked for years in close collaboration, also plays an important role. Although local, within the CCS programme, *mullahs* are actively involved at grassroots level, regarding the dissemination of key messages. Therefore, a logical next step would be to explore the possibilities of reducing violent practice in collaboration with the Ministry of Religious Affairs, in order to generate initiatives on a larger scale. Another important future key player is the Ministry of Higher Education so as to create modules about (family) violence related issues part of national curricula.

At provincial and district level Task force meetings at the provincial level with the Provincial Directorates of Ministries for Women's Affairs, Public Health, Education, Religious Affairs and Rural Development have been organised to ensure the inter-sectoral coordination among diverse actors when addressing domestic violence and gender equity. In two provinces (Nangarhar and Kapisa), where activities have been implemented since 2004 and 2006, these monthly coordination meetings are more successful than in the other provinces where activities have started later, or only recently. Awareness raising campaigns at provincial level are organised in close collaboration with these stakeholders, enabling women to show and sell products they made as a result of the current programme.

At district and community level The collaboration with community based organisations (CBOs) has proven to be very effective, as demonstrated through different programmes that HealthNet TPO has been implementing since 2004 (HealthNet TPO, 2011). As a result of the established networks at district level, women participating in this programme are also receiving practical help from CBOs through income generation projects, literacy classes, and vocational trainings, and through Community Development Councils (CDCs)[3] where women are invited to participate in specific rural projects.

'*Shuras*'[4] are specific local bodies, present in many districts of the provinces, but not always well organised. Many *shura* members, for example, get money from nongovernmental organisations (NGOs) to attend meetings, but are not actively involved once back in their own communities. To start female *shuras,* the permission of a village leader is required, but it is possible (Echavez, 2010). In Uruzgan province, a female *shura* with around 80 members gathers on a regular basis to discuss rural development issues (HealthNet TPO, 2011). Within the CCS programme, *shura* members and other key figures at grassroots level are actively involved. Village leaders, community elders and political authorities are informed about the purpose of the programme, and teachers, mullahs and female influential figures are mobilised to address gender related issues through their daily activities.

Component 3. Development of an action plan and intervention continuum

Although a rough activity plan was available before the start of the programme, detailed plans of action have been developed per target area, with local key implementers at different levels and based on identified problems, needs and available resources (component 1) and the existence of a network

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of social agents (component 2). The focus was on setting priorities, together with key implementers, and to translate plans into meaningful action. Making decisions, based on this shared vision may sound more complicated than it was; while mapping communities and discussing major problems and challenges, people developed a shared sense of what should and could be done.

The CSS programme is in its second year now. Because a single intervention is unlikely to meet identified needs, multiple interventions are amalgamated into a working system of support; i.e. an intervention continuum, or packages that address multiple types of needs within the years to come. Such an approach does not dictate the use of any specific interventions. Rather, it prioritises the facilitated transfer of people between components along a continuum of support, advocacy and adequate referral to organisations or services.

Some key principles

Experience has shown that the dissemination of key messages, across a broad population spectrum, helped to create the space to discuss the benefit or harm of specific practices. In this way, it appears to be more effective in terms of creating change, than targeting individuals or selected families for specific interventions. This was especially true when problems were related to the complex field of gender issues in relation to honour and shame.

Experiences also indicated that addressing culturally sensitive issues by using examples of the Quran should be an essential part of all interventions. Translating messages according to Islam appeared to be a prerequisite for success.

The family is the essence of life in Afghanistan. When violence occurs, all are involved and suffering is shared. Most problems are settled within families, and as long as the juridical and legal systems are not reinforced, victims of violent practices will not refer to external authorities. Therefore, women's protection and empowerment can only come through a systematic approach that engages the males of the community in all aspects of programme development, from planning to implementation.

Using mass media strategies to address harmful practices (consequences of high dowries or problematic relationships between mothers and daughters in law, etc.) also looks promising. In the cities, dramas on television appeared to be more effective than short radio messages. In the provinces, where there is not always electricity, these dramas might better be broadcast on the radio.

Component 4. Capacity building: ensuring the presence of skilled human resources

Capacity building can serve as a means to improve social cohesion, and is a process of direct empowerment through cooperative participation where people are invited to take responsibility from the very start. CSS aims to support people to manage their own health and wellbeing. Capacity building should, therefore, be defined within the context that the focus is not only on service provision. The whole idea is to enable populations in distress to take control of their own wellbeing through a diversity of interventions that can be provided by community actors. Within the current CSS programme, workshops are being conducted, enabling key figures to transfer key messages about gender related issues through psycho education or (support) group sessions. Community health workers receive training regarding the identification of people in need of more specialised care, and teachers are mobilised to integrate life skills into their

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curricula. The key issue is always to install local capacity to organise, implement and maintain initial efforts and work done.
Social oriented, community based activities are not yet imbedded into an existing governmental structure, and therefore depend fully on independent initiatives of NGO actors. Lobbying efforts within ministries, and building the capacity of CBOs to take over activities, are both important goals of the CSS programme. It is too early to determine whether this organisational and institutional capacity building will be successful. What is certain at this stage is that it takes time to build the necessary capacity to make efforts effective and sustainable.

Component 5. Community activities and direct service delivery
Awareness raising and psycho education The first step within the current programme was to inform the local population about the programme, while providing them basic education in (mental) health related issues as a result of harmful practices. The attempt here was to disseminate key messages among broad audiences by key local figures. For many people, basic information is an essential first step towards a behavioural change.
Group discussions The major purpose behind organising specific group discussions was to create a platform for social change among key persons like *mullahs*, teachers and other community members. Both men and women were invited to discuss existing practices (like early marriages, exchange of women between families to avoid dowry costs or to settle disputes) and possible alternatives. One of the challenges during recent years has been the sustainability of these discussions, which are welcomed at the beginning of projects but are difficult to maintain over a longer period. One of the recommendations is to integrate these group discussions within existing structures, like health committees, *shuras* or Community Development Councils, and to make topics like domestic violence, women's empowerment, etc., a cross-cutting issue of existing platforms.
Support groups or self help groups In a support group, people come together to tell their story or discuss a problem, with the specific aim of receiving support or learning from the other participants. While in a support group the facilitator still plays an important role, the group ultimately can become an independent self-help group. In Afghanistan, these groups have proven to be successful among women, especially in provinces where HealthNet TPO has been present since 2004 with psychosocial related programmes, as illustrated by the case study below.

> *'Some years ago we started a project; members of one of our support groups started to buy chickens from another NGO. Our support group members started to sell the eggs of these chickens and made some money. With that money they bought new chickens through that same NGO, as that was the deal. Although this NGO does not exist anymore, many women copied this practice and nowadays, in my direct surroundings, it has become common practice.' (Female psychosocial worker, Nangarhar).*

Structured and ongoing support The success of running support groups in Afghanistan has resulted in the design of the current EC programme, where 15 women in each of the 10 participating provinces are receiving continuous and structural support over a period of three years. During the first training, these women created their own vision for the future and outlined the actions that were needed to succeed. Provincial staff members of the programme visit on a regular basis to

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provide support. Extra training is provided, based on encountered challenges. The ultimate aim is to create networks where women are mobilised to take joint action aimed at reinforcing women's agency and wellbeing.

Collaboration with existing structures As many reported harmful practices are related to violent behaviour within, and between, families and many of these problems need a tailor made approach, a further exploration of existing resources within the community and family was necessary to discover how these sensitive issues could be resolved in a culturally appropriate way (HealthNet TPO, 2011) Most problems are settled within the families, or at a community level, but in the case of a big dispute, people or community elders will consult the district governor (Smith & Lamey, 2009). The reasons behind not taking disputes to the state are related to the weak juridical and legal system in place, and to social norms and expectations; it is shameful to take a dispute out of the village and share internal difficulties with outsiders. Similarly, there is a social expectation that people will first go to a *spin giray* (*'white-beard'*, a Pashtun term to indicate a respected elder in the family) with their problems. It would be disrespectful not to do so (Smith, 2009b).

While women's decision-making roles are restricted, people's opinions on what role women should or could play, in the case of domestic disputes, is often more progressive. Although women having a decision-making role in the *'jirga'*[5] is extremely rare, when discussing disputes between family members (particularly those that involve women), spaces in which women do influence dispute resolution processes can be found. These women are referred to as *'white-hairs'* (older women) and they are recognised for possessing similar attributes as the male members of a *jirga*: being trustworthy, just, and having knowledge of the community. As such, they are sometimes called on to advice other members of a *jirga,* and to help persuade those in dispute to accept the final decision[6] . According to the results of a recent unpublished survey (HealthNet TPO, 2011), there is a shift in the social set-up that has materialised over the last decades, explained below.

> *'In earlier times, people from a specific income group or power position would be respected, and were seen as role models. Due to ongoing violence and corruption, this aspect, or patron/client aspect of the relationship, has become much less [important]. There is a strong tendency among 'common villagers' to distrust the powerful people. They have not delivered as they were supposed to, in terms of protection and behaviour. Sometimes even men come to demand sessions together with women.' (Male key informant, Kabul, October 2010)*

Community elders and female influential figures are actively involved within the current programme, in an attempt to create a supportive platform for women while undertaking their activities. In years to come, more research will be needed to explore how these changing ways of handling disputes, conflicts and other culturally sensitive issues can reinforce CSS related activities, and vice versa.

Major conclusions

Applying the CSS framework in Afghanistan in an attempt to reduce domestic violence and to reinforce women's agency looks promising. More time is needed to measure the outcome of the approach, but the extensive and structural attention to community preconditions, in order to adapt the programme design to the local context, seems to reinforce the sustainability of interventions in a country where family, religion,

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traditions and informal relationships play an important role.

Building networks in order to undertake collective action is another essential step forward in a context where action towards an increase in women's agency may seem too risky for individuals, but becomes possible for groups through strength in numbers. An essential aspect of the CSS approach is to enable people in distress to take control of their own (health) situation by creating a cultural appropriate system of support. This can be achieved by reinforcing existing networks like *shuras*, CDCs, etc., and by establishing new systems of support.

Afghan society is changing; the implementation of activities aimed at a behavioural change among large groups of people should therefore be a flexible process, based on local needs and possibilities and responsive to social and cultural changes and phenomena. There are limits to the ability of programmes to transform social orders quickly. This argues for a more graduated and step-by-step approach, and a willingness to work within existing structures where they function well.

The data collected during mapping exercises can be considered as a baseline assessment, and have resulted in a first definition of change and implementation strategy, based on priorities, possibilities, available expertise and other context relevant issues. Conducting assessments should be seen as a continuous process of data collection. The current EC programme activities are closely monitored and evaluated, but much remains to be done. HealthNet TPO has engaged in a multi-year process of development and evaluation of the CSS approach that, in essence, aims to mobilise existing community resources to improve overall health, wellbeing and resilience within the targeted communities. The process of development and evaluation will use a phased process, based initially on action research principles that iteratively focus on implementation and assessment of implementation. This should culminate in conducting an evaluation of the effectiveness of the approach. In the end, this may lead to an evidence based approach to Community Systems Strengthening for Afghanistan.

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[1] For a definition of a community please see UNHCR Manual at: http://www.unhcr.org/refworld/docid/47da54722.html, March 2008.

[2] The Global Fund fight AIDS, Tuberculosis and Malaria and was created 10 years ago to increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need.

[3] The National Solidarity Program (NSP) is a World Bank funded programme covering all provinces of Afghanistan; the Ministry for Rural Rehabilitation and Development provides the leadership of NSP empowering rural communities to make decisions affecting their own lives and livelihoods through Community Development Councils (CDCs).

[4] S*hura* is an Arabic word for *'consultation'*. In Afghanistan it is used to indicate a representative council or group of people who discuss particular issues.

[5] A*'jirga'* is a highly flexible group that is formed on an ad-hoc basis to discuss and resolve particular problems and disputes.

[6] In many cases this *'final decision'* is about persuading the women to return to their husband's homes, while the husband has to agree to treat his wife better.

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