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# GENDER ASSESSMENT OF THE SOCIO-CULTURAL DETERMINANTS OF NUTRITION IN AFGHANISTAN (AUGUST 2014 TO JANUARY 2015)



JANUARY, 2015

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**Front Cover picture: Health awareness posters cover a wall in a clinic in Bandar Baharak, Badakhshan**

**Assignment Title:** Gender Assessment of the Socio-Cultural Determinates of Nutrition in Afghanistan

**Team Leader:** Anne T. Sweetser

**Team Members:** Dr. Humayoun Ludin, Nutrition Specialist, MoPH  
Manizha Wafeq, Gender and M&E Project Manager  
Mussarat Arif, Gender and M&E Specialist  
Kamal Burhan, M&E Specialist  
Hasine Omari  
Mohayuddin Shams  
Nadia Majrooh  
Naqibullah Sarhadi  
Nargis Majrooh  
Nooria Safi  
Rahmatullah Baidar  
Sayed Hayauddin Sadat

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**Waheed Ahmadi, Acting Chief of Party**

Checchi and Company Consulting, Inc.

Kabul, Afghanistan

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## ACRONYMS

AADA	Agency for Assistance and Development of Afghanistan (BPHS, Nangarhar)
ACTD	Afghan Center for Training and Development (Ghor)
AHDS	Afghanistan Health and Development Service (BPHS, Kandahar)
AKDN	Aga Khan Development Network
AKF	Aga Khan Foundation
AMA	Afghan Midwives Association
ARTF	Afghan Research Trust Fund
BHC	Basic Health Center
BPHS	Basic Package of Health Services
BRAC	Bangladesh Rural Action Committee
BDN	Bakhtar Development Network
CAF	Care of Afghan Families
CBHC	Community Based Health Care
CDC	Community Development Council
CHC	Comprehensive Health Center
CHS	Community Health Supervisor
CHW	Community Health Worker
DAIL	Directorate of Agriculture, Irrigation, and Livestock
DFATD	Division of Foreign Affairs, Trade and Development
DoE	Directorate of Education
DoPH	Directorate of Public Health
DoWA	Directorate of Women's Affairs
DRRD	Directorate of Rural Reconstruction and Development
EPHS	Extended Package of Health Services
FHAG	Family Health Action Group
IDP	Internally Displaced Person
IEC	Information, Education, and Communications
IHS	(Ghazafar) Institute of Health Sciences at Medical University of Kabul
IYCF	Infant and Young Child Feeding
IMAM	Integrated Management of Moderate Acute Malnutrition
IPM	Integrated pest management
MAM	Moderate Acute Malnutrition
MoE	Ministry of Education
MoHRA	Ministry of Hajj and Religious Affairs
MoPH	Ministry of Public Health
MRRD	Ministry of Rural Reconstruction and Development
NEI	Nutrition and Education International
NERS	Nutrition Education Rehabilitation Sessions
NSP	National Support Program
OAM	Organization of Afghan Midwives
PHD	Provincial Health Directorate (supervises BPHS)
PND	Public Nutrition Department (on MoPH)
PNO	Provincial Nutrition Officer
SAM	Severe Acute Malnutrition
SEHAT	System Enhancement Health Action in Transition
STC	Save the Children
TFU	Therapeutic Feeding Unit
VIP	Ventilated improved latrines
WASH	Water, Sanitation, and Hygiene

## **I. EXECUTIVE SUMMARY**

### **1. BACKGROUND**

Afghanistan has some of the worst nutrition indicators in the world. Nationally, 40.9% of children under the age of five are stunted, 9.5% are wasted, and another 25% are underweight.<sup>1</sup> Micronutrient deficiencies (Fe, Zn, and I and vitamins A and D) are severe. Roughly one-third of the population is food insecure.<sup>2</sup>

Nutritional status depends on food consumption and is affected by repeated episodes of disease; both are related to health care, agriculture, education, and water, sanitation and hygiene. All of these are influenced by underlying gender constraints and by political and economic realities. Globally, gender inequality is directly correlated with both acute and chronic malnutrition, as women's and girls' access to education, health care, and economic and decision-making roles are restricted.

This assessment explores gender constraints and opportunities to inform the design of a planned nutrition project in Afghanistan, focusing on the first 1,000 days of a child's life, starting at conception, at the household and community levels.

### **2. STUDY QUESTIONS, DESIGN, METHODS AND LIMITATIONS**

Culture, power dynamics, and dietary diversity are the key topics for understanding the knowledge, perceptions, and attitudes and behaviors that affect feeding practice.

The study team consisted of a Team Leader, four men and four women hired as local researchers, and two gender specialists from SUPPORT II. The team benefitted from the participation of Dr. Homayoun Ludin of the Ministry of Public Health (MoPH). The team leader designed separate interview guides and recording forms to promote conversational interviewing. These were translated into Dari and Pashto and adjusted after preliminary trials. The local researchers had little experience with field work of the kind needed for this assessment, so the Team Leader conducted thorough training, and supervised field practice plus initial research in Kabul. The team split for work in Kandahar and Badakhshan Provinces, and again for work in Nangarhar and Herat Provinces. With assistance from SUPPORT II staff members, the Team Leader, interviewed government agencies, NGOs, and donors in Kabul and in Badakhshan and Herat Provinces. Dr. Ludin interviewed government officials and NGO staff members in Kandahar and Nangarhar Provinces. Results were derived from all of the information that was collected: responses to survey questions, including detailed analysis of foods recommended for pregnant and lactating mothers and

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<sup>1</sup> GIRA and UNICEF, *National Nutrition Survey 2013*, pg 5.

<sup>2</sup> Ibid.

their babies; observations and reflections by team members; interviews with clinic staff; focus groups in each city; and interviews with officials, donors and NGOs.

The assessment was carried out during approximately two and a half months, and the sample was small and in urban and peri-urban areas for security reasons, introducing an urban bias. The Team Leader was restricted to the cities. Sampling was carried out by team members as they sought to balance young, middle-aged, and older people, and better-off, medium-income, and poor families, plus women-headed households. They visited clinics and nutrition programs with introductions from the administering NGOs, which potentially created a bias toward more communities with more successful programs. Team discussions were in English with some translation provided by SUPPORT II staff, but this affected the clarity of communication to some extent.

### 3. FINDINGS AND CONCLUSIONS

Cultural traditions, of both family and religion, have provided stability in Afghan society for centuries. In this patrilineal and patrilocal culture; males traditionally embody the family identity and women are brought into the home to produce the next generation of men. Often considered a burden from birth until she is married, a bride may be expected to toil under the stern gaze of her mother-in-law and may first gain respect when she has a son. She can be held responsible for failure to get pregnant, for having daughters, and for the ill-health of her children, and may be punished both physically and psychologically for these. When her son marries she attains some real power and often replicates the treatment she received when younger. A boy becomes a man when he marries and is welcomed into discussions among men in his community. Thereafter, he is judged by the behavior of his wife and children and subject to great social pressure to conform with shared norms and an accepted interpretation of Islam.. Considerable regional variation exists, and where small but growing numbers of young women, usually in relatively better-off urban families have received support to obtain advanced education, they are becoming increasingly active in the public sphere. Exposure to other societies, including while living outside the country during the years of civil war, has also catalyzed some cultural change.

Power dynamics are multidimensional and include political, economic, physical, moral, and psychological components. Individual status is largely ascribed: sex and then age are the primary determinants, but family history, economic status, education, piety, personal qualities, and reputation also influence one's position. Male elders meet in a *jirga* (traditional council) to decide on matters of shared interest and thus have political power within a community. The *mullah* and to some extent teachers are respected and exercise moral authority. Economic opportunity and potential wealth are most accessible to those with funding and the connections that facilitate access to good education and jobs. Physical power is seen in wife beating, abuse of young boys by pederasts, and sometimes in the treatment of young women by their mothers-in-law. Passive aggression and other psychological abuse may be used by women within the home, and in the form of social pressure to compel conformity among men.

Women's mobility is very limited. With few exceptions (including widows, and those whose

husbands are away for extended periods) they are required to obtain permission from their husbands, or perhaps their mother-in-laws, to go to a clinic. Similarly, the decision about participating in an activity outside the home is not theirs to make. Men need to know that what their wives or daughters will learn in a nutrition or other program is acceptable before they grant permission their participation. Thus, reaching out to men in a community first is necessary for arranging programs for women. The *mullahs* should also be informed by Islamic leaders (the Ministry of Hajj and Religious Affairs [MoHRA] may be influential in some cases) that the material is in accordance with Islam, It was noted thatt mullahs might undermine a development initiativeprogram if they are not contacted early and included in approving a program. arrangements.

An even more important reason for engaging men emerged from the detailed analysis of foods recommended by interviewees for women (before becoming pregnant, while pregnant, immediately post-partum, for the first forty days, and while breastfeeding) and for babies (to six months, from six months to one year, and from one to two years). Men listed many specific food items whereas women often referred to daily food or whatever was available. This called attention to the fact that men and women all reported that men do the shopping. It is obvious that men choose the foods for the family, and thus their knowledge of nutrition may be even more important than that of women.

Categorical labels for foods are frequently used, like hard, soft, and strong or energetic. Also, humoral concepts from Galenic-Islamic (Yunani) medicine appear to underlie feeding practices. No one recommended meat for pregnant women, possibly because both meat and a fetus are heating and excess heat might lead to fever. Immediately after delivery, chicken and other soups are strongly favored, and women stress meat, eggs and fat, possibly to restore heat as well as provide strength. While breastfeeding, they continue to emphasize liquids and to some extent sweets to support production of sweet liquid milk.

Most people reported giving colostrum to babies, but agencies that work for extended periods in rural areas cast doubt on their veracity. They cite beliefs that colostrum is milk that has spoiled by being in the breast too long. Few mentioned powdered milk or formula, but midwives urge development of a campaign to counter the appeal of these items. Though about ten percent of respondents said a baby should only receive milk until it is one year old, most spoke of introducing various soft foods after six months. As when speaking about foods for mothers, men again mentioned vegetables more than women for babies over six months of age.

Clinics seemed reasonably clean, were adorned with many posters, and appeared to be well-stocked. Lack of adequate female staff remains a serious problem. Without a shift system, it is hard for midwives to get regular rest, as there may be up to 70 deliveries a week in some areas. In the absence of substitutes, a midwife who must leave for a family emergency may be placing women's lives in danger. Vaccinators face accusations of trying to sterilize children in Kandahar, and nutrition education is not listed in any clinic staffs' Terms of Reference (TORs).

Health worker attitudes are reportedly poor; patients complain of being charged for consultations and medicines. Supervision and support of health workers amounts to little more than checking boxes on a list. Constraints on women's mobility, the distance to clinics, and the shame women may feel over a problem leads to delays in seeking treatment and often contributes to less than fully satisfactory outcomes. No special programs target men's health, so screening days might bring them into the health services and create opportunities for dissemination of information about the value of various foods and discussion of other health-related topics.

People often judge the quality of care they receive and the character of the practitioner by the perceived power of the treatment they are given: in ascending order, syrups, tablets, capsules, injections, and ultimately X-rays and intravenous drips are highly-valued. Even the color of pills and the design of the packaging affects peoples' views of medicines. People expect to be advised about foods to consume and avoid when they are given medicine, possibly reflecting beliefs about humoral balance and the need to counteract heating medicine with cooling foods. Local beliefs about specific causes of illness are best addressed by demonstrating a remedy than by arguing over the validity of those beliefs. Many people believe that seizures and mental illness are due to possession by jinns, so they fear an afflicted person and may fail to adequately help him or her.

The Ministry of Public Health's Basic Package of Health Services (BPHS) is administered an NGO in each province. Contracts are awarded through a competitive bidding process. The nutrition component was not prioritized in the design, and bidders did not fully fund relevant activities because, some reported, evaluation of the bids included 25 percent weighting for financial proposals. Though some NGOs have included nutrition activities in their BPHS work, separate programs like that of Save the Children (STC) and World Vision (WVi) attempt to fill the gap in addressing malnutrition.

Programs of both STC and WVi build on positive deviance by identifying poor women whose children are well-nourished and asking these mothers to share their methods with others. This may be done in the context of a two-week program in which the women cook together and learn how to use locally available foods to make high nutrient-density foods for their children with moderate acute malnutrition (MAM). In one village near Kandahar where this STC program had been implemented, people reported that many women are now making better food for their children.

These NGOs, as well as the Aga Khan Development Network (AKDN) and the UN, especially UNICEF, all have various counseling and micronutrient supplementation programs, including in- and out-patient treatment for children with severe acute malnutrition (SAM). They work with Community Health Workers (CHWs) and members of Family Health Action Groups (FHAGs) in villages and organize *shuras* (committees) around each health center or local health post. Only AKDN convenes compulsory monthly meetings of the *shuras* to ensure accountability to local residents.

Field crops are the primary responsibility of men, but women help tend and harvest produce and are largely responsible for livestock when they are not out grazing. The Food and Agriculture Organization (FAO), Aga Khan Foundation (AKF), and WVi have various school and home garden projects, some using cold boxes and greenhouses, to boost production and consumption of vegetables year-round. Nutrition and Education International (NEI) is developing a full value chain to promote soy production and consumption. Trust-based marketing collectives are greatly needed to help farmers realize the full value of their work.

Water, Sanitation, and Hygiene (WASH) is largely overlooked by Afghans as a cause of malnutrition. Pit latrines are sometimes near wells and may be contaminating them, open defecation is common, and hand washing is obviously not practiced as regularly as people claim. UNICEF and WVi are promoting odor-free latrines that create fertilizer, and UNICEF is piloting Community Led Total Sanitation (CLTS), which motivates people to build and use latrines by leading them on a 'walk of shame' in their villages. Waste water is thrown on the ground or into a well, garbage is very rarely composted, and both paper and plastic are burned, the latter introducing dioxin into people's tanduri bread. A tandur is a large bee-hive shaped ceramic oven with a relatively small opening at the top. A fire is kindled at the bottom and large ovals of thin dough slapped against the interior sides where they cook quickly before being removed with a long fork or stick.

Schools are urged to include gardens and hand washing and link these to their curricula, but without specific support from the Ministry of Education (MoE) administrators are reluctant to devote much effort to these initiatives.

In addition to the news, people with access to media listen avidly to a long-running family drama that addresses social change and some health issues on BBC radio, and urban women who are allowed to watch TV greatly enjoy a Turkish soap opera in which the husband treats his wife very well. There is scope for an Afghan drama, as well as spots on relevant topics.

While regional variations remain, change is occurring in urban areas throughout the country. Women, especially, are getting more education, and some are moving into professional jobs. Age of marriage is slowly increasing, family size is a bit limited by economic pressures, and the choice of a marriage partner is being broached in some circles. Movement of refugees to Pakistan from the south and east, and to Iran from the west, has exposed many people to alternative lifestyles and introduced new ideas into society. People are eager to leave the years of fighting behind and build a better economy and more stable country.

#### 4. RECOMMENDATIONS

These recommendations are for USAID and for any organization that seeks to promote nutrition through improved feeding practices, health services, agricultural production, education, or initiatives in water, sanitation, and hygiene.

##### *Community Level Nutrition Programming*

- Work with the MoHRA to ensure *mullahs* are informed of any new programming and for approval of new ideas disseminated.
- Work with men first because women cannot participate in training programs or other activities without their permission, and are unable to implement behavior change within the home without men's support. Make sure they are comfortable that the content is not in any way offensive.

Teach the men about nutrition because they decide what foods will be eaten when they do the shopping and they are better educated so easier to teach.

- Start with the *malik* (community leader) or *wakil* (community representative) and the elders, as they are the opinion leaders. Involve health shuras, community development councils, and local health workers.
- Offer to help men fulfill their important responsibilities as Muslims to care for their families by sharing information that will improve their children's health.
- Employ male educators when speaking with men about reproductive health.

Employ concrete examples in all information, education, and communications (IEC).

- Consider linking nutrition education for men with men's health days with mobile teams.

##### *Women's Community Nutrition Programs*

- Create group-based activities and locate activities for women within easy walking distance of their homes and in places where they are shielded from public view.
- Go beyond teaching and demonstrating – beyond telling and showing – to engage people in the hands-on learning that is necessary to foster behavior change among adults and among predominantly illiterate populations.
- Consider seeking out examples of positive deviance, reinforce existing good practices, and promote sharing of information and practices by women.

- Employ locally available and affordable materials. In cooking programs, teach women to preserve vitamins by not cooking foods at too high a temperature.
- Follow-up with each community in the short- and medium-terms to verify adoption of new practices and address any issues that may have arisen.
- Include information to counteract the appeal of powdered milk and formula for babies in nutrition education programming as it may be inappropriately mixed with contaminated water and delivered in unsanitary bottles.
- Work with the MoPH and medical training institutions to incorporate in the curriculum modules on both nutrition and ‘bedside manner’ to improve practitioner attitudes and encourage them to listen carefully, even when people employ models of the body and illness that differ from how they are trained.
- Engage with MoPH and other donors on developing, incentivizing, and funding effective supervision and support for health workers.
- Promote shift scheduling and availability of substitutes so that health workers can get regular rest and do not leave clinics understaffed in the event of a necessary absence.
- Support programs that address fistula reconstruction. By assisting women with this debilitating problem, the health system would gain public confidence to better support other initiatives such as nutrition education.
- Support development of community nursing programs to upgrade community-level care giving.
- Support rights-based approaches to dealing with gender-based violence, sheltering victims, and enforcing punishments for perpetrators.
- Promote family counseling (a woman plus her mother-in-law and/or husband) for family planning so all learn about the methods simultaneously.
- Promote mentorship programs for new health staff to help them gain confidence and minimize errors.
- Assess public comprehension of the posters that are liberally distributed to clinics, and also post them in markets and government offices to reach a wider audience.
- Support development of local radio and TV program(s) or serial(s) that incorporate attention to mother and child health and nutrition, as well as try to change Afghan family and social norms and behaviors.

### *Education*

- Promote the incorporation of nutrition information in curricula for students at multiple levels, and for teachers both in training and in service.
- Assist with the development of appropriate teaching materials and linking educational activities for children with good practices, such as sprouting seeds in class or planting and caring for a tree in the school yard, practicing hand washing, collecting recyclable plastics during community clean-up days, etc. Work with the Ministry of Education in all initiatives related to education to ensure their support within schools.

### *Agriculture and Livestock*

- Create marketing associations among men and women producers to ensure they sell at the right times and places to receive good prices.
- Build these organizations very carefully to ensure clarity on rules and responsibilities, as well as benefits for members, and institutionalize transparent and accountable leadership and financial management to foster trust among the members.
- Introduce cold boxes for senior men as well as women and greenhouses for local groups. Offer demonstrations and hands-on learning programs to promote off-season production, consumption, and sales of vegetables.
- Through radio and TV spots and possibly school programs, promote urban gardening in yards or in pots to support better nutrition.
- Support installation of solar water pumps for irrigation (and other uses). Durable technology that does not require purchase of expensive fossil fuels would contribute to enhanced production of food.
- Promote construction of post-harvest storage facilities, including simple underground cold storage where feasible.

### *WASH*

- Advocate for and support expansion of community-led total sanitation programs to address severe sanitation problems and the diseases to which they contribute.
- Consider promotion of odorless, fertilizer producing ventilated improved latrines.

- Promote production and distribution of affordable, easily-maintained water filtration systems for drinking water.
- Support solar water purification systems for appropriate locations, possibly starting with trials in food processing plants. (If a woman can sew, she can solder, provided there is good ventilation, and can learn to install wiring inside homes, while men could be employed to install external solar collectors on buildings and homes.)
- Promote recycling of plastic bottles to make boxes for shipping produce and other items rather than using very scarce wood resources and adding to burgeoning solid waste.

### *Overall*

- Be extremely careful to avoid inappropriate promises – unmet expectations very quickly lead to disillusionment and undermine motivation to contribute .
- Actively promote adoption of results monitoring in all programs and assign responsibility for it. Provide necessary support for it on an ongoing basis.
- Provide or secure a long-term commitment to supporting all activities.
- Build on one activity to support another initiative – for example, offer to assist women who took part in a cooking program with home gardens the next year.
- Integrate the health, education, agriculture, and WASH dimensions of nutrition programming within communities to optimize clearly demonstrated results.
- Require community contributions to any construction project or other activity.
- In all activities, give local people time to express their ideas and ask questions. Listen carefully to what people are trying to say, including when they are thinking about a problem or issue in a very different way.
- Work with existing *shuras* or established groups with specific responsibilities related to a new initiatives. Coach groups on staying focused on their tasks to enhance their effectiveness by reducing friction that may easily develop when aims are not clear.
- Promote regular meetings of local *shuras* or other groups to ensure that activities are accountable to local people and are therefore more likely to be sustained.

## II. INTRODUCTION

### 1. BACKGROUND

With some of the worst nutrition indicators in the world, Afghanistan has about 7.6 million food-insecure people (roughly 30 percent of the population).<sup>3</sup> The poor, women, children, internally displaced people, and returning refugees are most vulnerable. Almost 41 percent of children under the age of five are stunted, half of them severely; 9.5 percent are wasted; another 25 percent are underweight, as are 9.2 percent of their mothers. Micronutrient deficiencies in these groups are severe: 40.5 percent of mothers and 44.9 percent of children are anemic; 11.3 percent of mothers and 50.4 percent of children are vitamin A deficient; 23.4 percent of mothers and 15.1 percent of children are deficient in zinc; 40.8 percent of mothers and 29.5 percent of children lack sufficient iodine; and 64.7 percent of mother and 64.2 percent of children are vitamin D deficient. Over 60 percent of mothers do not know about anemia and close to 70 percent are unaware of vitamin A.

Nutritional status depends not only on the availability, accessibility, and consumption of foods. It is also directly affected by hygiene and sanitation, repeated episodes of illness and treatment, and by the knowledge, beliefs and practices of both educated and illiterate people. Repeated episodes of illness and acute malnutrition during the first two years of life lead to stunting, which affects cognitive and emotional development, as well as smaller physical stature. The health and nutritional status of the mother before and during pregnancy and while breastfeeding directly impacts the child, as do feeding practices throughout the child's first two years. Malnutrition causes more than one-third of child deaths globally and countries suffer substantial economic losses due to malnutrition as well. The 2012 Copenhagen Consensus concluded that "every dollar spent on reducing chronic malnutrition has at least a \$30 payoff."<sup>4</sup>

Gender inequality is directly correlated with both acute and chronic malnutrition. It is a factor to the cyclical perpetuation of poverty. Deeply-held cultural traditions related to women's and girls' rights limit their access not only to food but also to education and information, preventive and curative health care, economic opportunity, and decision-making roles in both domestic and public contexts in Afghanistan.

### 2. ASSESSMENT PURPOSE

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<sup>3</sup> This statistic, as well as the others cited in this paragraph comes from: GIRoA and UNICEF, *National Nutrition Survey 2013*, pg. 5.

<sup>4</sup> Cited in USAID, OPPD, *SOW for Gender Assessment of the Socio-Cultural Determinates of Nutrition*, pg 3. See pg. 61 of this document.

The purpose of this assessment is to prepare evidence-based recommendations on gender-related constraints and opportunities for the design of the planned Improving Nutrition Outcomes for Target Populations Project. Recognizing the multiple sectoral contributors to malnutrition, and aiming to effectively and sustainably reduce malnutrition during the first 1,000 days of a child's life starting at conception, the assessment covers agriculture, health, education, and water, sanitation, and hygiene (WASH), as well as food consumption.

### 3. ASSESSMENT QUESTIONS

Culture, power dynamics, and dietary diversity are the key topics for this study, in order to understand the knowledge, perceptions, attitudes, and behaviors that affect feeding practices. The focus of this assessment is on the household and community levels to complement recent studies that have focused on nutritional status, national policy, planning, staffing, guidelines etc., and on program implementation at the provincial and health center levels.

- a. **Cultural traditions:** What are the cultural traditions that limit the diversity of women's diets during pregnancy/ breastfeeding and the practices of feeding young children?
- b. **Power dynamics:** What are the dynamics within households or communities that prevent or enable family members to have access to adequate nutritious food, potable water, and health services?
- c. **Diet diversity:** What are the nutritional gaps in the diets of people at different geographic and socio-economic levels, and what causes those gaps?

### 4. METHODS AND LIMITATIONS

Prior to arriving and also while in Afghanistan, the Team Leader reviewed relevant documents. Checchi SUPPORT II arranged for Dr. Homayoun Ludin of the MoPH to take part in the assessment, along with three members of the Checchi Monitoring and Evaluation team. SUPPORT II also recruited a team of four men and four women with skills in English, Dari, and Pashto. Most of the eight team members were young and lacked experience in employing qualitative research methods and conducting surveys.

The Team Leader met with Dr. Ludin upon arrival in country and they worked together on the schedule for the assessment and on preliminary question lists for interviews with men and women, clinic and community health workers, and household and clinic observation. Since the interviewers would be working in teams, the Team Leader decided to prepare separate question lists and recording forms in order to promote more conversational interactions with respondents. These were translated into Dari and Pashto and minor changes were made after completing the work in Kabul province.

Team training covered the causes and consequences of malnutrition, qualitative vs. quantitative research methods, observation and listening skills, types of questions and question strategies, focus group facilitation skills, and note taking. (See Appendix V)

Interview and focus group practice was carried out in Kabul. Additional interviews and clinic visits in Kabul city and Paghman district followed.

Subsequently, the team split in half, with two men and two women traveling first to Badakhshan and Kandahar provinces, and later to Herat and Nangarhar provinces. The teams were restructured for the second set of provinces so one man and one woman visited each pair of provinces (Nangarhar and Kandahar, Kandahar and Herat, Herat and Badakhshan, and Badakhshan and Nangarhar). As in Kabul, they conducted rural and urban household interviews, clinic visits, and health worker interviews, and made observations at clinics and households. In each provincial capital, one focus group was conducted with young men and one with young women, and full transcripts prepared. Following the return from both trips, the full team discussed their findings.



**Figure 1: The assessment team conducted a focus group with women in Faizabad, Badakhshan.**

The Team Leader conducted interviews with federal ministries and provincial directorates, donors, and NGOs in Kabul, Badakhshan, and Herat Povinces. Dr. Ludin conducted interviews with provincial directorates and with implementing agencies in Kandahar and Nangarhar Provinces. Checchi SUPPORT II Monitoring and Evaluation staff assisted with many of these interviews as well.

Analysis of the findings depended upon reading all of the interview and observation reports, focus group transcripts, notes of team discussions after each province, and notes of interviews with development organizations. Detailed analysis of foods reportedly given to women and children involved compiling lists of all responses to each question by province, gender of respondent, and rural or urban residence. These lists were analyzed by hand. Each time a particular food was named it was counted as a separate item, and the number of responses from men and women in urban and rural settings was calculated. As some people mentioned several food items and others only one or perhaps two, the findings do not correlate with the number of people who answered each question. Variation among responses by region within the small sample was negligible, so a detailed analysis of foods by province was not pursued.

### *Limitations*

The assessment was conducted in a limited period of time and involved a small sample (household interviews were carried out with close to 90 men and 90 women. The study was conducted in major provincial cities and nearby areas due to security concerns, which introduced an urban bias to the results. Insurmountable security concerns necessitated that team members stay quite close to major urban areas. The Team Leader was restricted to the cities and not able to observe rural areas or interact with citizens. The only exception was one hurried visit to a clinic near Kabul. Sampling was carried out by the team members, who were instructed to balance old, middle-aged, and young interviewees; well-off, middle-income and poor families; and to include women-headed households, and followed this .

Selection of clinics to visit was made in conjunction with the NGOs that are implementing the Basic Package of Health Services (BPHS) in each province. These NGOs were usually contacted through the Provincial Nutrition Officer (PNO) in the Directorate of Public Health (DoPH), as well as by the Team Leader. Again, a major factor in the selection of a clinic was the security situation in its immediate area and along the roads between the city and the clinic. Selection of a second village in each province was usually made with support from an NGO that is implementing a nutrition project thereTeam Leader. A desire by NGOs to show examples of successful work possibly introduced bias toward more successful project areas.

The results highlight patterns that are common to men and women in widely separated regions of the country despite the possible biases mentioned above. Based on semi-structured interviews, observation, and comparative discussion among team members, they are indicative rather than statistically valid and fulfill the requirement of identifying key features of gender issues for nutrition programming.

Team discussions were conducted largely in English, although team members were most comfortable with Dari and some with Pashto. Translation (and other) support was provided by Checchi SUPPORT II staff.

## **III. FINDINGS**

### **1. CULTURAL TRADITIONS**

#### **a. The Family**

Afghan families, the backbone of society, are patrilineal and patrilocal – family identity is embodied by men generation after generation. After marriage, a woman usually moves to her husband’s home, where she may be regarded as an outsider for many years. Though change is

occurring in major urban areas and variations exist among families and regions, a baby girl is often less valued than a baby boy. She must be cared for and perhaps educated until she is married, shortly after reaching puberty in many parts of the country. Her father, possibly with input from other family members, decides whether or not she will be educated and to what level, possibly to 4<sup>th</sup> or 7<sup>th</sup> grade. After that, she may be considered too mature to appear in public and withdrawn from school to protect the family honor. The family usually decides when and to whom she will be married. She might be promised soon after birth to a relative, or, rarely, given to settle a dispute or atone for a crime committed against another family (*baad*). Sometimes, a very young girl is married to an elderly man, possibly due to the extreme financial difficulty of her natal family.

In her new home, she is expected to fulfill her husband's demands for sex and, under the critical gaze of her mother-in-law, to toil day in and day out cooking, cleaning, washing clothes, helping to harvest agricultural produce, caring for livestock, and doing any other required tasks. Stories of abusive treatment are not uncommon, and a small number of reports of suicide by drowning or by fire were heard in both relatively progressive and very conservative provinces. A health worker commented that the youngest brides, those of as little as seven years of age, are least able to tolerate their circumstances and thus most likely to seek escape in this way.

Women's roles have traditionally been confined to home and reproduction, and these is widely assumed to encompass their interests and capabilities. Usually pregnant soon after marriage, even if her body is not fully grown and thus able to carry and deliver a baby safely, women are generally considered responsible for the sex and wellbeing of their children. Failure to become pregnant or to contribute to the sustainability of the family by producing sons is typically seen as a personal failing. Midwives reported that some women cry when they hear they have delivered a girl. Some beg not to be compelled to take the child home from the clinic, preferring to report that the child was born dead, since a stillborn boy at least proves they are capable of fulfilling their greatest responsibility. There may be sympathy for the tragedy rather than blame, contempt, withholding of good food, and possible beating and curses for the failure.

One woman reported being threatened with expulsion from the home if her next child were another girl, a fate conceivably worse than death for a woman without education or means of support. A woman whose child was defective and died after a few months of life reported that this was construed as evidence that she had been cursed by Allah. She was beaten and cursed by the family, and her husband arranged a second marriage. Her life is totally ruined, she said. Another woman delivered a very beautiful boy, which led the family to accuse her of having an affair. She was beaten and cursed until she convincingly swore her innocence. A woman rarely has any control over her husband's decision to remarry or to engage in pederasty; in either case she may be relegated to a denigrated role of household help. Survival compels submission.

Birth of a boy, by contrast, is reason for great joy and celebration. The midwife may receive money and boxes of chocolates, and AK-47s may be exuberantly fired into the air. For the new mother of a first son, the child typically brings her some respect for the first time in her life, and she may be given especially good food for some days. The child assumes great importance for his mother, who will dote on and derive emotional substance from him. He promotes his ties to and dependency upon her, and fosters his sense of importance beyond the limits of home and family. If, however, the son is not followed by another boy in a few years, the woman may again be harassed by the family. By contrast, the mother of a girl, as well as the child, may not be fed well by the family. In Kandahar, 30 of 33 (91 percent) malnourished young children recently seen in a clinic were girls.

A woman attains a new and significant level of power when her son is married and a young bride enters the home. With a potential competitor for the son's loyalty in the family, the new mother-in-law may exercise her prerogative to put the young woman in her place and demand obedience. Though psychological pressure to fit in and quickly adopt the practices of her new home is commonly felt by new wives, a few young women reported being fed poorly as a form of punishment. Two young women who displeased their mothers-in-law were chained in the family compound and kept in a shed. Thus, a mother-in-law may stereotypically replicate the difficulties to which she herself was subjected earlier in life.

Great changes also occur in the son's life when he marries. He is now regarded as a man and welcomed into the community of men when public issues are discussed. Depending upon other features of his status, such as the prominence of his family and his age vis-à-vis that of his brothers, he may soon be given a chance to speak in these gatherings as well. He is now held responsible for everything that happens within his family – what his wife and later his children do and do not do brings honor or shame upon him, so he feels compelled to dictate what they may and may not do. The pressure for conformity within the men's community is very great; the influential man who wishes to introduce change will carefully build support before openly promoting his idea. Within the family, his ability to influence decisions also increases upon marriage, again depending upon birth order and his personal qualities, and especially if his father is old or infirm.

## **b. Religion**

Group pressure enforces a single accepted interpretation of Islam within a community. The person who openly questions an accepted interpretation may be deemed to be a *kafir* (unbeliever) and is potentially under serious threat from those who do not want impurity or evil in their midst. Even students at a religious college in Jalalabad who asked their professor for an explanation of a passage in the Quran were told that if they had to ask they were *kafirs*. The students felt that the man was using the accusation as a veil for his ignorance. Members of the research team were distressed to observe the extent to which many *mullahs* were poorly educated and espoused views that they felt were not correct. They strongly hoped the government would require all *mullahs* to be well-educated. The conviction that there is but a

single correct meaning of Islam despite its textual complexity is widely-held, and this in turn contributes to difficulty in accepting pluralism in many Islamic societies.

While many men responded positively to a (leading) question about the desirability of learning more about reproductive health in order to fulfill their religious duty of supporting their wives, some older men in conservative areas commented that it was shameful for men to even know about such things. Virtually all men stated that a mother should breastfeed for two years, and many cited Islam as the reason rather than any information and education communications (IEC) sponsored by donors. One *mullah* stated that he would be glad to speak about nutrition-related topics in the mosque, but was afraid that he would lose his job as local residents might object.

## 2. POWER DYNAMICS

Status is hierarchical and largely ascribed in Afghanistan. First and foremost sex and then age determines a person's position in the family and the community. Men are the decisionmakers, at least until they are away fighting or killed, leaving a woman with young children in charge and fending for herself. A person's intelligence, piety, ability to deal with people effectively, and reputation for honorable behavior also affect his position. Other factors that reflect both the person and his family include the length of time the family has resided in a given area, economic status, and level of education. An educated man in a well-off family that has long been influential in an area is most likely to be affiliated with an organization outside the immediate community and thus have considerably wider connections (vertical social capital). A poor child has much less chance of obtaining a good education due to illiteracy at home and lack of the all-important connections to help gain admission to government colleges.

Achieved status through social mobility depends largely on the underlying ascribed properties, but there is nonetheless considerable flexibility. A man who loses his job is diminished while a woman who supports her family, especially with a government or other salaried job, is elevated, at least within the family. An educated young man may introduce new ideas to his family by influencing his mother and, through her, his father long before he replaces his father as head of the family. Aspersions of immoral behavior by the women in a family may seriously affect the public standing of a man who fails to punish any such suspected violation. Migration to neighboring countries during the recent decades of fighting has created opportunities for young people who were educated abroad, and has shown many Afghans alternative ways of organizing social life.

Key members of a community are the elders and the *mullah*. The elders meet in a *jirga* to discuss matters of shared concern and settle disputes. Teachers also have traditionally been much-respected. There are also community development councils (CDCs) and health,

education, and other *shuras*. Some health *shuras* reportedly include a few older women or are composed only of women.<sup>5</sup> The National Solidarity Program (NSP), founded in the early 2000s to promote participatory community development, gives the opportunity for a group for women to bring a case of gender-based violence or family conflict to the *jirga* and demand a balanced resolution. Smaller initiatives include Family Health Action Groups, volunteers who assist the community health workers (CHWs), and trial creation of spinnsary groups consisting of elder women.

Authority may be either coercive or based on influence, and power may be physical, psychological, economic, political, or moral. A woman may influence her husband by offering suggestions but not challenging his prerogative to make the decisions in the family. The strategy available to her for pressuring him to take her ideas into account is generally passive aggressive: she may prepare food poorly when she is displeased. Men, however, often respond to frustrations with force and beat their wives. Economic hardship (while stressed by the need to support their family and conform to male group pressure), perceived slights such as poorly-spiced food, or comments by other men about the behavior of women in their family may trigger violence. A man in a community where the team conducted interviews had killed his wife because she sold some wheat without his permission. With as much as 40 percent of the population regularly using hashish and up to five percent addicted to refined opium, drug use is also commonly noted as a cause of wife beating, possibly related to the financial cost of the drugs.

Physical force, the most basic form of coercion, may also be used by women, as in the examples of mothers-in-law who chained young women in the family compound and in a shed. In other cases psychological pressure was seen when young women were cursed and threatened with punishment or expulsion from the home for failure to produce sons. Limiting a daughter-in-law's access to food is physical coercion, but also telling her that the family does not have to feed her because she is not of their blood, as in the case of one family interviewed, is psychological abuse.

Moral authority may be employed by members of a local *jirga* when settling disputes. Restorative rather than punitive justice is often the result. When this involves giving a young girl to the aggrieved family to settle a dispute, it violates the fundamental human rights of the girl and underscores the perception of females as property of men. Several men, seemingly in an effort to prove how progressive or modernized they were, spoke of "giving" their wife or daughters "all of their rights." This usually meant allowing them to go to school or to go to the clinic without specific permission on each occasion. Moral authority can also be abused, as by the unscrupulous *mullah* who recently raped a ten year-old madrassa student so brutally

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<sup>5</sup> In Ismaili communities, which make up a small percentage of the Afghan population and are concentrated in a few provinces, women reportedly make up half of the health shura members.

that he nearly killed her and then claimed that according to sharia she should be stoned to death for her crime. Ultimately, he was sentenced to 20 years in prison.

Political power, or influence over public decisions, and economic power are often closely related. Wealth confers opportunity to gain a good education and this may create new economic opportunity and the potential to gain influence over decisions in wider circles. Locally, those most able to affect the outcome of a discussion in the *jirga* are not only well-spoken individuals; their status and authority are reinforced by their ability to make things happen by mobilizing resources to support community decisions, such as the construction of small-scale infrastructure, or using their contacts to seek external support for some project. One man gave land for a school but refused to allow his daughters to study, potentially gaining both political and moral status.

### 3. DIETARY DIVERSITY

Each respondent was asked detailed questions about foods for women before and during pregnancy, immediately after delivery and through the first 40 postpartum days, and while breastfeeding. Each was also asked about foods for babies during their first six months, from six months to one year, and from one to two years of age.

As noted in the earlier methodology section, team members prepared lists of responses to each question by province, gender of respondent, and rural or urban residence, and these lists were analyzed 'by hand.' Each time a particular food was named it was counted as a separate item, and the number of times each item was mentioned by men and women in urban and rural settings was calculated. As some people, especially men, mentioned several food items and others only one or perhaps two, the findings do not correlate with the number of people who answered each question. Variation among responses by region within the small sample was negligible, so a detailed analysis of foods by province was not pursued. Also, the fact that security constraints prevented the team members from traveling far outside the provincial capitals means that the results are probably somewhat urban-biased, even though most interviews were not carried out in cities.

Few provided full responses to all of these questions. In Kandahar, women were very suspicious about the intent of the interviewers and what would be done with the information; they were perceived by team members to frequently give evasive or incomplete answers. Some apparently feared that they might be punished for talking with outside women. In Nangarhar province, quite a few women were also very reluctant to respond. In one home where team members were interviewing a woman who was active as a leader of a spinnery group (of elder women), her second son screamed hysterically at the team and demanded they leave his house for fear that his reputation as a leader in the mosque would be besmirched by the presence of girls there. Some of the data were naturally affected by these attitudes.

One result immediately stood out. Men frequently mentioned some combination of fruit, vegetables, beans, meat, chicken, eggs, nuts, and milk, while women most often said daily, common, and normal food, or whatever is available. Each respondent had also been asked to identify who made what decisions in the family, and with virtually no exception, shopping is the responsibility of men. Thus, it was clear that, contrary to expectations of a society in which women both plan and prepare meals, women are not directly involved in choosing what food to cook. They might mention some food that they would like (after possibly gauging the ability of the man to purchase it), but often hesitate to make such requests, lest they be thought greedy or ungrateful.

Qualitative categories of food were often mentioned, but rarely were these defined, despite the fact that interviewers were urged to probe for details. Common food was equated with rice and potatoes; daily food with beans, okra, and eggplant. These responses correlated well

with reports of food prepared at home in the past 24 hours. Bread, though a staple at meals, was not mentioned. Other categorical food labels were strong, energetic, healthy, good, and hygienic. Of these, strong was at least once defined as meat, chicken, eggs, and vegetables.

a. **Foods for Women of Reproductive Age** (see Table 1)

**Table 1: Food for Women (First 1,000 Days of a Child's Life)**

	<b>Before Pregnant</b>	<b>While Pregnant</b>	<b>After Delivery</b>	<b>First 40 Days</b>	<b>While Breastfeeding</b>
<b>Daily/normal</b>	Women 51/58*	Women 43/49	--	Women 20/27	Women 32/42
<b>Fruit</b>	Men 38/42	Men 26/41	Men 16/20	Men 12/13	Men 17/25
<b>Vegetables</b>	Men 29/33	Men 18/28	Men 5/5	Men 7/9	Men 17/20
<b>Meat</b>	Men 14/14		50/50 (M21, W23)**	Women 11/18	Men 11/14
<b>Chicken / nuts</b>	Men 5/5	Men 6/9	Men 11/18	Men 8/12	Men 6/6
<b>Chicken soup</b>			Women 11/18	Women 2/3	Men 2/2
<b>Egg</b>	Women 6/6		Women 22/27	Women 7/9	Men 8/8
<b>Beans</b>	Men 7/7		--		Men 3/4
<b>Milk/yoghurt</b>	Men 8/10	Men 10/15	50/50 (M3, W3)		Men 15/17
<b>Good/energetic</b>		Men 9/10	--		Women 7/10
<b>Lety</b>			50/50 (M10, W11)	Men 7/9	
<b>Soup/yakhni</b>			Women 21/33	50/50 (M22, W22)	Women 7/9
<b>Soft / shola</b>					Men 3/3
<b>Oil/ghee/halwa</b>			Women 12/20		50/50 (halwa) (M3, W3)
<b>Liquid / tea</b>					Women 12/12
<b>Fish</b>					Men 2/2
<b>Vitamins and Protein</b>					Men 2/2
<b>Total responses and # women's responses</b>	n=121 women=71	n=119 women=64	n=110 women=57	n=111 women=64	n=115 women=56

\*Women 51/58 = women gave 51 out of a total of 58 references to daily/normal food.

\*\*Men and women gave (almost) the same answers, men gave 21 and women gave 23

For women before they become pregnant, only men mentioned meat (14 mentions), chicken (5), and beans (7), and only women mentioned eggs (6). Men also made the majority of references to fruit (38 of 42 responses), vegetables (29 of 33), and milk and yoghurt (8 of 10), while the majority of women said daily or normal food (51 of 58).

All responses about foods for women to avoid before pregnant came from men. They mentioned medicines / prescription medicines (12), hard foods (5), cold liquids and harmful foods (2 each), oily foods, spicy foods, and beef (1 each).

For women while they are pregnant, neither men nor women mentioned meat. Men gave the most responses for fruit (26 of 41 mentions), vegetables (18 of 28), chicken (6 of 9), milk and yoghurt (10 of 15), and good or energetic food (8 of 10). Once again, women most often mentioned daily or normal food (43 of 48 responses). A very small number of women also mentioned eating red clay-laden soil that has been traditionally used for washing hair. Possibly, they are craving the minerals (calcium, iron, copper, and/or magnesium) that this type of soil usually contains.

Again, it was men who most listed foods for a pregnant woman to avoid. They mentioned medicines and hard foods (5 times each), spicy foods (3), cow's milk, sour foods, foods that cause sideeffects (2 each), and dairy, yoghurt, beef, oily food, and salt tea (once each). One woman mentioned eggs, and another said a pregnant woman should avoid heavy work.

For postpartum women, the pattern was very different, especially for the first few days after delivery. Again, only men mentioned vegetables (5 of 5 responses), and they most frequently mentioned fruit (16 of 20), and chicken (11 of 18). Men and women equally noted milk and yoghurt (3 each), *lety*, (wheat and oil boiled with sugar) (women gave 11 of 21 responses). No woman mentioned daily or normal foods for this period of time, instead they mentioned meat slightly more frequently than men (23 of 42 mentions), and listed several other foods more frequently: soup and *yakhni* (broth) (21 of 33 responses), chicken soup (22 of 27), and eggs (22 of 27). Women also mentioned ghee, the fat of fat-tailed sheep, and *halwa* (a grain-textured dessert) more than men (12 of 20 mentions). Desire for fat was particularly strong among rural women.

The length of time women were treated to special foods varied: one man said that women get good food for only one day, one said a week, one ten days, one two weeks, and one ten to 15 days. The Afghan Midwives Association (AMA) reported that women in the east are given chicken soup for seven days after delivery; and in the northwest, a bird is fried in oil and the oil given to the new mother to eat with bread.

During the first forty days after delivery, a woman may be considered impure, so diet during this period was queried separately. Soup was the most frequently mentioned food: men and women each mentioned soup and *yakhni* (soup broth) 22 times, with *yakhni* mentioned twice as often as soup in rural areas. Women continued to stress eggs (7 of 9 responses) and meat (11 of 18) more often than men, and many mentioned daily or normal food (20 or 27). Men noted fruit (12 of 13 mentions), vegetables (7 of 9), chicken (8 of 12), and *lety* (7 of 9) more often.

Many fewer items were said to be important to avoid immediately after delivery. One woman in Kabul (city) said to avoid pulses, vegetables, legumes, beans, berries, and cereal; and one man in Kabul said to avoid sour, spicy, and gas-inducing foods. Three men in other provinces mentioned cold water, sour, and bad foods. No foods to avoid were listed for the first forty days.

For women while breast feeding, only men mentioned chicken (6 times), chicken soup (2), egg (8), soft food or *shola* (rice gruel) (3), fish (2, in Nangarhar), and vitamins and protein (2, in Kabul and Herat). They also dominated responses on fruit (17 of 25 mentions), vegetables (17 of 20), meat (11 of 14), beans (3 of 4), and milk and yoghurt (15 of 17). Only women mentioned liquid and tea (12 responses), and gave the most responses for soup and *yakhni* (7 of 9), daily or normal food (33 of 42), and good or energetic food (7 of 10). Equal numbers of men and women noted *halwa* (3 each).

While breastfeeding, only medicine and sour and spicy foods were listed, once each, as things to avoid. Possibly, this was due to fatigue, as the questions in this section were repetitive and the questionnaire was long, and perhaps some of the items mentioned earlier applied to later questions on foods as well.

**b. Foods for Babies** (see Table 2)

A large majority of respondents noted that a baby should be breastfed for two years, whether due to Islam or donor IEC programming, as noted above. All also replied that the first milk is given to babies, often commenting that mother's milk is strong or healthful. Interviewers were instructed to specifically ask about colostrum (fila). Giving the 'right' answer to an interviewer and actually implementing the advice are, however, different. The National Nutrition Survey of 2013 reported that 87.5% of the population gives colostrum. But Save the Children (STC) – with staff in districts and communities over long periods of time compared with visits by this team and staff of the national survey – reported that the rate of initial breast feeding is in fact very low. Instead, babies are usually given a mixture of butter, tea, and water wrapped in a cloth to suck on. Older women, they said, believe that colostrum is milk that has spoiled because it has stayed in the breast for a long period. A mother-in-law often decides on the location of the delivery and other practices around childbirth, for example by maintaining that going to a clinic is shameful and was never necessary in the family before (and thus implying that the daughter-in-law is too fearful and does not trust the family). Therefore, she might insist on withholding colostrum from a new baby despite effective dissemination of information about its value.

**Table 2: Food for Babies**

	<b>Birth to Six months (Add)</b>	<b>Six months to One Year</b>	<b>One Year to Two Years</b>
<b>Soft / well cooked food</b>	One man	Women 24/41*	Men 13/16
<b>Daily / normal food</b>		Women 23/31	Women 49/91 (75% of responses)
<b>Mother's milk ONLY</b>		Men 12/16	One woman
<b>Dry Milk</b>	1 only, 1 preferred, 1 added	50/50 (M8, W8)**	50/50 (M4, W5)
<b>Add animal milk (1 goat)</b>	2 men 1 woman	Men 6/10	Men ¾
<b>Cerelac</b>	3 men	Men 14/16	Men 5/5
<b>Shola</b>	1 man, 1 woman	Men 10/15	Men 12/13
<b>Soup and Yakhni</b>	1 woman	Men 9/11	Men 7/9
<b>Banana</b>	1 woman	Women 8/11	
<b>Potato</b>		Women 8/10	
<b>Vegetables</b>		Men 7/9	Men 8/10
<b>Biscuits</b>	3 men	50/50 (M5, W4)	50/50 (M3, W3)
<b>Rice</b>	1 woman	50/50 (M4, W4)	
<b>Meat (including shorba)</b>		Men 4/4	
<b>Sauce</b>		50/50 (M2, W2)	Men 5/5
<b>Ferni</b>		Men 3/4	
<b>Egg</b>		Men 2/3	
<b>Fruit</b>	1 woman		
<b>Butter</b>	1 man		
<b>Total and # of women's responses</b>	N=149, women=75	n-148, women=82	n-122, women=64

\*Women gave 24 out of a total of 41 responses.

\*\* Men and women gave the same number of responses, eight men and eight women mentioned this food.

Not surprisingly, everyone mentioned milk as the key food for babies during their first six months of life. Mothers vary widely in the number of times they breastfeed their babies each day, some saying as few as two or three times, others saying up to 20 times a day. STC noted that the rate of exclusive breast feeding is nearly 60 percent. One person suggested the addition of powdered milk, one said it should be the only milk, and another said that breast milk should be used only if powdered milk were not available. The Afghan Midwives Association (AMA) believes a campaign to counter the appeal and increased use of powdered milk and formula is needed, suggesting its popularity is greater than indicated by the survey. Two men and one woman recommended adding cow or goat milk. A few mentioned other foods to be given in addition to milk: soup, banana, rice, and fruit (one woman each); butter and soft/well cooked food (one man each); and biscuits (cookies) and cerelac (three men each). One man and one woman each mentioned *shola*.

The list of added foods is much longer for babies between six months and one year of age, though men gave 12 of 16 responses (close to ten % of interviewees) that a baby should receive only mother's milk. Another 16 respondents, half men and half women, mentioned powdered milk; one stated that a baby should be given only it if the mother's milk is unavailable. Also, ten respondents, six of whom were men, mentioned cow and goat milk. As with women's foods, men listed more items than women: cerelac (14 of 16 responses), *shola*, (10 of 15), soup and *yakhni* (9 of 11), vegetables (7 of 9), feni (corn meal, oil and sugar) (3 of 4), and eggs (2 of 3). Only men mentioned meat (4 times). Women gave the most responses about soft/well-cooked food (24 of 41 mentions), daily or normal food (23 of 31), banana (9 of 11), and potato (8 of 10). Essentially, equal numbers of men and women listed biscuits (5 men and 4 women), rice (4 each), and sauce (2 each).

Hard foods were the most frequently listed food to avoid (21 responses); others were beans and pulses (5), meat and spicy food (3), strong, not well-cooked, and hard to digest foods (2 each), and potato, peas, and gas-producing foods (1 each).

For babies between one and two years of age, one woman said mother's milk was the only food that should be given. Five women and four men mentioned powdered milk, and three men and one woman mentioned cow and/or goat milk. Three quarters of all responses were daily or normal food (men mentioned this 42 times, women 49 times). Once again, men gave the widest variety of responses: soft and well-cooked food (13 of 16 mentioned), *shola* (12 of 13), soup and *yakhni* (7 of 9), and vegetables (8 of 10). Only men mentioned sauce and cerelac (5 responses each). In addition, three men and three women mentioned biscuits.

Once again, hard foods topped the list of things to avoid (6 responses). Spicy foods were mentioned by two; and peas, raisins, spinach, 'not good tasty food,' and 'harmful food like beans and peas' were each mentioned once each. Additional comments were that they should

not be allowed to eat too much, that they should have as much as they can eat, and that they should not be allowed to eat soil.

Though respondents had said a baby should be breast fed for two years, most of the responses to questions about foods for children from six months to one year and from one year to two years did not include reference to breast milk. The extent to which the foods mentioned were complementary or the only foods given to the children is not clear in these data.

### c. Discussion

A total lack of understanding of the process of breaking down food and rebuilding nutrients after eating is evident in these responses. Though daily or normal foods may contain some meat (or meat juice if others eat first), neither men nor women specifically mentioned meat as appropriate for a pregnant woman. General qualities of foods appear to be taken into account when judging their value. A woman needs to become strong after delivery, so that is when they say she most needs strong foods like chicken, meat, eggs, and fat. Similarly, to restore fluid lost during the delivery and support production of (sweet, liquid) milk, she should consume more tea, soup, and sweets than at other times. Lack of adequate milk seems to be a common problem; failure to appreciate a woman's need for adequate and varied foods while breast feeding no doubt contributes to this. Especially if an undernourished woman becomes pregnant again, she will be unable to continue to produce milk. She might also be led to feel that her inability to continue breastfeeding her child is a personal failing similar to not becoming pregnant or producing sons.

Humoral concepts of Galenic-Islamic (Yunani) medicine are relevant, though not articulated by citizens during this assessment. In this medical system, each individual has a unique temperament or balance among hot and cold, and wet and dry, and is healthy when balanced appropriately. The foods one eats quickly affect one's balance among the humors: blood, hot and wet; phlegm, cold and wet; bile, hot and dry; and black bile, cold and dry. People's emotional tone reflects their natural balance, giving them a sanguine, phlegmatic, choleric, or melancholic personality. (The English language obviously retains these categories plus other humorally-grounded expressions as well, such as cool as a cucumber.) A person is very hot as a baby, and slowly cools through life; and men are hotter and drier than women of the same age. People are subject to cold wet (phlegm-y) diseases during a rainy winter, especially older (cooler and wetter) women. People are short-tempered and subject to fevers in summer, especially young (hot and dry) boys and men. A pregnant woman may be hot due to the fetus and therefore advised to avoid heating (or strong, energetic) foods such as meat, but needs these to restore heat after delivery. Ingesting large quantities of fluid to support milk production may prevent a woman from becoming too dry.

A person is said to be 'strong' or 'healthy' when he or she is at least plump, and 'weak' is used for a person who is thin, without reference to muscle development. Conceivably, therefore, a food that is said to be 'good for you' or can 'make you strong' is assumed to be 'energetic,' or what a nutritionist would call 'high calorie.' Perhaps the well-educated, urban team members who understand that fruit and vegetables are high in calories had heard similar messages about the general benefits of these foods and, ignorant of physiology, translated them from 'good for you' to 'give you lots of energy' or 'helps you put on weight.' Similarly, though, some people mentioned multivitamins or protein; it is not clear that they really understand what these are and how they contribute to metabolism. As noted in the introduction, over 60 percent of mothers do not know about anemia and close to 70 percent are unaware of vitamin A.

#### 4. HEALTH CARE

Team members visited health posts in rural villages, basic health clinics, and comprehensive health centers in some cities. At each of these they interviewed one or more health care workers: midwives, nurses, CHWs, or doctors. In addition, the focus groups they conducted in each provincial capital included many health workers and trainees. The Team Leader and Dr. Ludin also interviewed NGOs that implement BPHS and other organizations in each of the provinces visited by team members. Information from these interviews, and from interviews conducted by the Team Leader in Kabul, provided information that complemented data gathered by the team.

Conditions at the clinics varied but generally they appeared to be well-equipped and well-stocked, though staff reported difficulty in obtaining needed replenishments on time. Cleanliness was very good when the staff were aware of the intended visit; less so when they had not been forewarned. In one clinic, a midwife tried to hurriedly clean after a very recent delivery, believing that the team was on an official inspection mission. No space is reserved for nutrition education in the clinics; so far, this is an extra duty imposed upon health workers but not in their job descriptions. CHWs and members of the Family Health Action Groups (FHAGs) are volunteers and expected to visit every home in their village on a monthly basis. Their training is very limited and they receive no compensation for their efforts; yet many programs expect them to carry out a range of tasks, overloading their schedules and possibly exceeding their capacities. Apparently, many simply fail to act after they have received some training. Patients complain that they are asked for payment for consultations and for medicine at clinics, both of which are supposed to be free. Without cash to purchase medications in the bazaar, there is little they can do if only given a prescription.

Understaffing, especially of women health workers, is a serious problem in clinics. Midwives report that few women come for antenatal care, while in some areas they may deliver up to 70 babies in one week. Stillbirths are not infrequent and, they say, are often due to the woman being beaten by her husband while pregnant. They complain about the lack of a shift system to ensure that someone is always on duty and that allows them to get regular rest. When a midwife has to leave her post for a funeral or other family emergency, there is no one to step into her place. If a woman has ridden for hours on a donkey but finds no female staff at the clinic, she must return home and is unlikely to be given permission for another trip.



**Figure 2: A health clinic in Bandar Baharak, Badakhshan**

Vaccinators face serious problems in conservative areas where vaccinations of either mother or child are believed to cause children to be cowards and/or sterile. Doctors who promote vaccination are labeled *kafirs* for 'trying to destroy the next generation of Islam.' Women come surreptitiously for vaccines while pregnant and refuse to give their husbands' names for fear that the vaccinator will report them to their families. Also, vaccinators may be denied entrance to family compounds and/or cursed when they attempt to fulfill their responsibilities by going door-to-door. If they fail to meet their targets, they may feel compelled to misreport their accomplishments to avoid being penalized.

Important problems identified by organizations that work with communities are poor health worker attitudes and poor supervision and support. Greater patience than many demonstrate is required for dealing with the illiterate people who seek care. If their conceptual models of the body and disease processes differ from those of the health workers, they may feel disrespected and think their problems are not understood or properly treated. Supervision and support frequently boils down to ticking boxes on a checklist; talking with and helping health workers are rare, and the opportunity for analyzing and addressing systemic problems (as encountered by vaccinators in some areas) is lost. Also, the budget for supervision and support is rarely available.

Women and children are the most frequent visitors to clinics, but a man may also bring children for treatment if he does not want his wife to leave the family compound. Permission for a woman to go to a clinic for treatment or advice is often mentioned as evidence that a man has given his wife her rights. Restrictions on women's mobility often cause delay in seeking treatment and compromises the likelihood of cure. Sometimes it is the mother-in-law who has the right to grant permission for a trip to the clinic. In one case, a mother-in-law was away when a nine-year old girl developed a very high fever. Afraid to go without her permission, other women in the house let the girl die. Some programs that promote family planning request the woman come to the clinic with her mother-in-law or her husband so all learn about the methods simultaneously.

Distance is another barrier to clinic attendance in many areas. In mountainous areas, tiny villages are nestled at the base of extremely steep and remote valleys. A local midwife may try to save a woman with a difficult delivery, but there is no real alternative for many people in these areas. Even in urban areas, distance is a major constraint. Men and women responded enthusiastically about the possibility of various training programs, but consistently said the programs must be very close to home if women are to participate at all.

Men seek treatment less frequently at the clinics and there are no programs specifically designed for addressing their healthcare needs. Separate waiting areas are not set aside for men and women in most clinics, which may contribute to limiting women's permission to go to clinics, and may also deter men from going to clinics near their homes. Women may delay treatment because they feel shame about their problems; this is particularly true for fistula, and there is little opportunity to obtain adequate treatment for this. Men's health days might be a way of bringing them into the system, providing screening for preventable conditions such as hypertension, and educating them on a variety of nutrition and health topics.

Yunani concepts are again evident when people attribute a (hot) child's fever to eating too much (heating) meat, and blame a sore throat on eating ice cream or drinking cold water. People expect advice on foods to eat, or more likely to avoid, when taking medicine, probably (originally) to ensure that their hormonal balance is not upset by the medicine. On one occasion, the Team Leader recommended iron, folate, and calcium for a woman in her eighth month of pregnancy, when her mother-in-law reported that a doctor had said she should not eat meat or milk because there were contaminants in her blood. Failure to name foods to avoid while taking these supplements was disturbing to the mother-in-law, apparently connoting a lack of qualification to recommend medicine.

Various traditional beliefs may affect nutrition and health-seeking behavior. For example, in Badakhshan, many people believe eggs, meat, and grapes will make a child deaf, and that seeds of fruit will cause appendicitis. Deafness (and cretinism) is actually due to thyroid malfunction, caused by a lack of iodine in the diet and easily prevented with fortified salt, which is reportedly available in much of the country. Similarly, many people believe that seizures and mental illness are due to possession by jinns and thus greatly fear (rather than support) a person who is depressed or afflicted with epilepsy.

People judge the quality of care they are given and the ability and character of a practitioner by the perceived strength of the remedy he or she gives. Syrup is said to be least powerful, followed by tablets, capsules, and the much more efficacious injections. For more serious problems, an X-ray or, best of all, an intravenous drip may be considered necessary. With almost no exceptions, people are unaware of the type of medication they are given; only two mentioned paracetamol and one health worker referred to a complex sulfa drug as something to be avoided when pregnant. Families may keep herbs at home and try these first when someone is ill, but keeping aspirin or vitamins in the home was never observed during this assessment.

## **5. HEALTH AND NUTRITION PROGRAMS**

Included in the interviews conducted by the Team Leader were NGOs that manage BPHS in provinces, and the AMA and its membership group, the Organization of Afghan Midwives (OAM). The Aga Khan Development Network (AKDN) and Care of Afghan Families (CAF) manage BPHS in Badakhshan, the Bakhtar Development Network (BDN) in Herat, Agency for Assistance and Development of Afghanistan (AADA) in Nangarhar, and Afghanistan Health and Development Services (AHDS) in Kandahar. AKDN has programs in Bamyan and Baghlan provinces as well. STC manages BPHS in Kunduz, an integrated program in Uruzgan province, and nutrition programs in ten other provinces. World Vision (WVi) also implements a nutrition programs in three western provinces. The most successful of these programs devote significant effort to work with communities through CHWs supervised by Community Health Supervisors (CHSs).

The AMA offers several levels of certification and has trained over 3,000 midwives. This includes limited training on nutrition, but a new curriculum will include a full module on it. Significantly, the association noted that safe motherhood programs only address women,

which limits their effectiveness. Man-to-man communication is also needed to change behavior around pregnancy and early childhood development. AMA's outreach on nutrition includes mother-in-laws as well as mothers at the clinics. Still, however, only 34 percent of births are attended by skilled attendants. AMA pairs novice and experienced midwives in mentorship programs, demonstrating a model for effective supervision and support that might be adapted for other health care (and other service) providers. AMA is a member of the Asia Breast Feeding Association and its campaign for the first 1,000 days.

In Herat, BDN provides six months of training for CHWs and refresher sessions every six months. Each CHW covers between 250 and 500 households, receives basic medicines and supplies every one to two months, and refers patients to clinics for more difficult problems. CHSs control, supervise, and support 50 CHWs and provide feedback to clinics on the patients seen and on the supply of medicine at the health posts. Members of Family Health Action Groups (FHAGs) are expected to visit each house every month and refer any new problems to the CHW. Turnover is high because people are not compensated for this task; instead many take advantage of the training offered but then say they are too busy. At minimum, the training is an effective way to disseminate some information at the community level.



**Figure 3: A Health clinic in Aten Jelow, Badkhashan**

Mobile health teams, including a doctor or doctor's assistant, nurse, midwife, vaccinator and driver, focus on women's health. They set up a temporary clinic in the *malik's* home or village center and provide vaccines, medicines, and family planning advice and services. In order to reach women, BDN suggests getting to the children. Also, the organization notes that if a woman is trained but the husband is not educated on the same issues, behavior change will not occur. BDN mentioned a national mobile phone service for calling a short number to hear health awareness messages. A significant feature of the BDN BPHS program is the inclusion of psychological counselors in health center staffs and dissemination of information on depression and other mental illness.

AKDN is widely known for long-term investment in the communities where it works, and this is no less true in Afghanistan. In each community, the organization has created a WASH committee, and its public health program includes environmental education; hygiene, including hand washing and, uniquely, teeth brushing; nutrition programming; iron and folic supplementation for pregnant women; and breastfeeding counseling. As in BPHS in all

provinces, AKDN health posts have two staff, usually a husband and wife, who receive medicine, family planning supplies, and IEC material every month. The FHAGs include men and older women, in addition to trained birth attendants. In addition, they form a council of ten to 12 of the most respected people in the community. Crucially, this group has compulsory monthly meetings to ensure accountability in service provision.

National initiatives of AKDN include collaboration with the Ministry of Hajj and Religious Affairs (MoHRA) to prepare a 100-page book on hygiene, which is nearly ready for dissemination. The network has trained/are training over 200 community health nurses, as well as midwives. And all of its basic health clinics (BHCs) are linked through satellite; if cell phone is unavailable, they can reach Comprehensive Health Centers (CHCs) and through them provincial hospitals, Kabul, and ultimately the Aga Khan Hospital in Karachi, with assistance from the French Medical Institute for Children (FMIC), for telemedical support to remote areas.

STC has a prevention-oriented antenatal care program that provides a micronutrient package four times to a pregnant women, and offers at least one consultation with a midwife. Women are advised not to eat too much salt or oily food and are given folate supplements. Each quarter the program meets with district *mullahs* to explain things about food and sanitation, and CHWs sometimes meet with school teachers to share health and nutrition information. STC's upcoming project will include an orientation session for all citizens as well. Like AKDN, all STC clinics have health *shuras* composed of both men and women. They noted it is necessary to be clear about limitations in the system so members do not make unrealistic requests and become disillusioned when the requests cannot be fulfilled. CHWs explain topics like weaning to its members. If a community lacks a clinic building, STC may donate materials but require local residents to carry out the construction work. The organization notes that community investment is the key to successful implementation of all types of projects. It also urges implementers to be extremely clear about expectations and avoid making irresponsible promises, lest disillusionment stymie the best-intentioned programs.

#### **a. Nutrition programs**

The nutrition programming that was intended to for inclusion in BPHS has been largely under-implemented. Interviewees pointed to a lack of capacity of the original designers and of the NGOs that bid on the project, and to a lack of clear priorities in the Mop at the time. Others noted that inclusion of fully-funded nutrition programs in proposals would have made them uncompetitive because the proposals were evaluated on both technical merit (75 percent) and cost (25 percent). NGOs and donors that are members of the Partnership Advisory Committee, which meets in Kabul every six months to share progress, challenges, and plans and offer constructive criticism to one another, have apparently recommended that contracts instead be awarded on the basis of technical merit only.

The separate programs like those of STC and WVi (supported by DFATD/Canada) play a particularly important role in addressing nutrition in Afghanistan at this time. They have worked in communities and are therefore able to reach women and engage them in the hands-

on learning that is necessary to introduce behavior change among predominantly illiterate populations. They have built on positive deviance, encouraging sharing among women in those communities as well. A similar local-group-based approach has been employed by AKDN and some UNICEF and other UN programs as well.

In the twelve provinces where it works, STC organizes nutrition education rehabilitation sessions (NERS). These are a preventive, community-based program in which mothers get together with CHWs or FHAG members for 12 days of cooking high-nutrient density food using locally-available ingredients. They also offer health and nutrition education. Good foods and cooking methods used by some in the community are shared and new ideas introduced by the program. It starts with a one-day orientation for men covering the importance of good nutrition and the causes and consequences of malnutrition. They also explain the STC program and what villagers can expect from it. STC staff (usually women) mobilizes the community, follow-up, and monitor the implementation carried out by CHWs and FHAG members.

In addition to the antenatal care mentioned above, other STC programs are Infant and Young Child Feeding (IYCF) counseling at community and health facility levels, and treatment interventions. These programs involve outpatient feeding in communities and counseling at health centers. Treatment programs include screening in communities to identify malnourished children. Severely acutely malnourished (SAM) children are referred to CHCs or hospitals, while feeding groups like NERS are established with caregivers' participation for moderately acutely malnourished (MAM) children.

The World Vision program, Maternal and Under Five Nutrition and Child Health (MUNCH), in Herat, Badghis, and Ghor provinces is very similar. Project staff goes to villages, identify malnourished children, and set up mothers' groups to cook together for ten days. They demonstrate cooking different meals using locally-available foods each day for the mothers to continue to prepare and the results are checked later. They also seek out poor families in which the children are well-nourished in the same community or in adjacent villages and ask those mothers to teach other women. WVi also offers IYCF training to FHAG members in the catchment areas around health posts, covering systematic breastfeeding, complementary feeding, and the importance of good nutrition. Community mobilization efforts focus on intensive community sensitization through mosques, *shuras*, and CHSs. By relying on the FHAG members, they give voice to community members and listen to what they have to say. For integrated management of acute malnutrition (IMAM), they organize outpatient therapeutic feeding, and for severely acutely malnourished children they support therapeutic feeding units (TFUs).

AKDN's nutrition programming is linked with its BPHS programs in which they employ a holistic, community-based approach, as noted elsewhere. It sponsors preventive provincial forums that cover pregnancy and lactation, group monitoring, vitamin A for post-partum women, exclusive breast feeding to six months, complementary feeding, and diarrhea and parasite control. AKDN provides flour fortification at a cost of \$3/month/household and are

working toward local fortification and ending subsidies. It also organizes groups of school children, at least in Badakhshan, to maintain cleanliness in their villages.

The Provincial Nutrition Officer (PNO) in Badakhshan noted that if both men and women receive information, the women grow more vegetables; and he added that health workers are trying to teach women not to overheat vegetables when cooking them in order to preserve the vitamins. During nutrition week, three teachers in each school are trained in nutrition and sent back to teach other faculty. He also said that doctors are unaware of women's need for iron and the role of folate, and prescribe inappropriate doses. The DoPH therefore sponsored a one-day training program for them and included nurses and midwives. He also mentioned that the color of iron tablets can be very off-putting, so attractive packaging is very important.

Several UN agencies are working in nutrition. The World Food Program (WFP) provides school lunches in some areas, supplementary foods programs for MAM, and collaborates with other UN programs such as UNICEF. In 2006 in Badakhshan, it started to develop marketing for winter vegetables. At first only tomatoes, potatoes, and onions were sold, but now all types of produce are available, some from local women and some even imported. The WHO has introduced growth charts in some regions and may conduct an assessment on the efficacy of the many posters they have been distributing for decades. It is developing a monitoring system and checklist for the national nutrition monitoring and surveillance systems of the MoPH, and has developed therapeutic feeding units (TFUs) outcome indicators and monitors in-hospital TFUs. The Food and Agriculture Organization (FAO) has organized 750 groups in three districts chosen in consultation with the Directorate of Women's Affairs (DoWA) in Badakhshan. The communities identify needy families, and then FAO transfers knowledge to women and, lacking funding for greenhouses or other programs, sponsors a clean house initiative. A new project works with men to produce fruit tree saplings and then to share some of these with women's groups. FAO also noted that when the men were away fighting, women produced better vegetables and tree crops than the men.

UNICEF sponsors a range of nutrition activities. For IMAM, it has both in- and out-patient treatment programs. It carries out community mobilization for awareness raising, screens children under five years-old and counsels their mothers, disseminates IYCF communications, and airs TV and radio spots about breast feeding, complementary feeding, and maternal health. It provides micronutrient powder for six to 23 month-old babies on an emergency basis and supports the WFP feeding program for MAM. For adolescents, it is planning weekly iron supplementation through schools and outreach to out-of-school girls. It advocates for private areas for breastfeeding in offices so women can continue their careers after having a baby. In Badakhshan, it also works with CAF on breastfeeding, complementary feeding, and IYCF in community groups of mothers, FHAGs, and CHWs, with supervision from CHSs. It found that women who previously squabbled when brought together in groups, are now working well together because they have an important topic on which to focus. UNICEF collaborates with the MoPH and played a leading role in the National Nutrition Survey. It will add nutrition officers in its five regional offices in 2015, and is planning to expand to 11 provinces where no other donors are working on nutrition. It also cross-checks

the BPHS budgets of NGOs that submit side proposals to ensure that they are not double-dipping and requires those that are funded to include more staff in addition to money for their transportation.

## 6. AGRICULTURE

Agriculture is the mainstay of the rural economy. It accounts for one-quarter of GDP, and three-quarters of the population rely on agriculture for their food and livelihood. Close to half of the land is rangeland and over a third is barren.<sup>6</sup> The climate is arid to semi-arid, so except for the northern plains, irrigation based on snow melt in the central Hindu Kush is essential for production of crops. Altogether about five percent of land is irrigated and another seven percent is used for dry land crops. By far the largest crop in the country is wheat, followed by barley, maize, and rice. In Badakhshan, winter wheat is sown on the dry, light brown hills in the fall and matures when the snow melts in the spring. Both nut and fruit tree crops are grown in addition to vegetables. Sheep outnumber all other livestock, including cattle (used for traction and dairy production as well as meat), goats (like sheep, grown for wool, meat and milk), donkeys (commonly used for transportation), and horses. Decades of fighting have seriously deteriorated the infrastructure that supports farming, yields have dropped, and livestock numbers have decreased as well.<sup>7</sup>

This assessment found that women help with tending and harvesting crops. They are also primarily responsible for the care of livestock (except those that are out for grazing or taken in communal herds to summer pastures). In Herat, they work in saffron production, separating it from the crocus flower but they have little control over the business itself. They also produce some poultry for the market.

Men are responsible for growing crops, and those who reported production of fruit and vegetables usually sold at a very high percentage. What and how they decide the amount to retain for home use was not probed in depth, but it appears that cash income was prioritized over family nutrition, possibly to pay tenancy fees or settle pressing debts. Many complained of receiving poor prices from greedy middle-men, highlighting the need for development of local collective marketing schemes to facilitate the timing of sales and protect the producers' incomes.

During the winter, women are responsible for keeping the fire going for heat as well as for cooking, care for the children and the house, and work with the wool that is not sold from the animals, including tying carpets. Men go to the mosque, cut wood, and may work in their shop, work as a driver or guard, or seek daily work as laborers. Older men go to the mosque and keep snow off the roofs, but otherwise have little to do. To quell their boredom, they may even assist with cutting vegetables or other light tasks around the home.

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<sup>6</sup> USAID, *Afghanistan*, "Agriculture," <http://www.usaid.gov/afghanistan/agriculture>, Accessed Nov. 20, 2014.

<sup>7</sup> FAO, *Country Pasture/Forage Resources Profile*, "Afghanistan," <http://www.fao.org/ag/AGP/AGPC/doc/Counprof/afgan/afgan.htm>. Accessed Nov. 20, 2014.

### a. Agriculture and Livestock Programs

A small number of programs support school or home/kitchen gardens. These include FAO, WVi, AKF, and NEI. FAO has been supporting women in agriculture to promote better nutrition, particularly among pregnant and lactating women. For the past seven to eight years, it has been collaborating with a focal person appointed by the provincial Directorate of Education (DoE) in Badakhshan and in a few other provinces to identify one school per district for a school garden. If an assessment of available land and water, and the level of interest among teachers and students is promising, FAO fosters development of a small agriculture committee in the school and works with them to develop a plan, including identification of a teacher to lead the effort. A plan is also developed for the students in which the gardening is linked to specific lessons for two to four classes in each school. The home economics department of the provincial Directorate of Agriculture Irrigation and Livestock (DAIL) trains the teacher and monitors the project. FAO provides seeds, tools, and a guidebook covering nutrition for teachers and others responsible for the program. Some groups of women in various districts have asked for food processing equipment.

FAO's community garden project in six villages starts with meeting the community development council (CDC). Lists of the numbers of children, and pregnant and lactating women are requested from the *shuras*. Land is requested from others if the women do not have enough of their own. FAO selects a Team Leader and sets up a meeting to discuss pests and diseases. They deliver a package of materials for integrated pest management (IPM), which includes information on farm management, processing, nutrition, literature for school teachers, and greenhouses for trainers. Monitoring is handled jointly by the DAIL, DoWA,

and DoPH. They visit villages at every harvest and offer relevant information and advice. (This plan presumes that funds for travel are available for the government departments, which is often not the case.)

World Vision is working in three provinces in Western Afghanistan (Herat, Badghis, and Ghor). It is providing materials for small cold frames for home gardens to 3,000 women and for construction of five greenhouses at the health facility level. When these are complete, WVi will contribute seeds as

well. It is not working on school gardens. Instead, it promotes healthy eating at schools by training teachers and also encourages the teachers to make their own kitchen gardens.



**Figure 4: A man transplanting seedlings in Karokh village, Herat**

To promote the engagement of women in decision-making, the organization is providing incubators for chickens to groups of 40 women at the health post or village level. 400 chicks are hatched and each participant receives ten to raise. During the first round, WVi provides eggs and food for the chicks. A few roasters are also given to start producing eggs right away. It follows up with vaccinations for the chickens and works with extension workers in MAIL to train women on how to do the vaccinating. Though not seeking to create a cadre of para-veterinary workers, WVi hopes that female vaccinators will eventually be certified at the extension level. Cold boxes are provided for distribution of the vaccines after they are removed from the refrigerator. Later, DAIL is expected to provide the vaccines. (In an interview with the extension service, it was made clear that the directorate has no budget for activities other than from donors, so the sustainability of the vaccination program is unclear at this time.)

Nutrition and Education International (NEI), a US-based NGO, has been working for a decade to develop the complete value chain for soy production, dietary supplementation, and marketing. Farmers in districts in many parts of the country have been trained to grow soya beans and provided with seeds and other inputs. After identifying farmers who were really interested, they assessed needs and held one-day workshops on the importance of soy (its amino acid profile), planting, land preparation, diseases, pests, harvesting, storing, and marketing. Each year the amount of urea fertilizer required is diminishing due to introduction of healthy bacteria (rhizobium) to the soil. They monitor twice every year, randomly selecting half of all fields each time. This year, the third since planting started in Herat province, NEI is purchasing 60 percent of the crop from each farmer. It then manufactures soy milk to donate to hospitals and give to needy citizens. It is now expanding and opening shops to sell soy directly to the public in some provinces. NEI is also fostering provincial-level soy farmers associations, which may facilitate cooperative marketing in the future.

NEI trains 40 school teachers in each pilot district (not necessarily the same districts as where soy is grown) to prepare soy *korma* (a stew with spices) and bread with ten percent soy flour. The bread has far higher protein content than plain wheat bread and it stays moist for up to three days, reducing the need to make bread every day. The *korma* is made by cooking the soy beans (which require heating to be fully palatable) with onion, garlic, tomato, spinach or other greens, etc. Each teacher is expected to train 25 women in her village. At the end of the program, each trainee receives 25 kilograms of soy flour and five kilograms of soy beans.

AKF is promoting diversification in agriculture by improving access to nutritious seeds for trees and gardens. For example, it brought hybrid apple seeds from areas with similar climates to Badakhshan. The foundation employs a holistic community-based approach, working with farmers in communities where it assists with healthcare and schooling for children. It provide inputs and greenhouses for off-season vegetables, work to improve the technical capacity of farmers, support marketing development, and help residents build low cost, pest-controlled underground cold storage units. AKF's most successful small- and medium-size enterprise (SME) development project has been backyard poultry raising. 80 percent of eggs are sold through quality-controlled marketing networks. It was designed after value chain research. Also, the program has helped create local savings groups for people

who are working in agriculture-based businesses to promote long-term sustainability. Over 70 percent of the 3,000 members of these groups are women.

Some smaller programs, including STC, have small-scale home garden demonstration programs. This is accompanied by community-based sessions to share information about micronutrients. Oxfam has a new project to give sheep and chickens to women (at least in Badakhshan).

## 7. EDUCATION

Like FAO, WVi, and NEI, many organizations target schools for dissemination of knowledge and practices intended to promote better nutritional status. AKDN sponsors a clean village campaign through schools in the districts where it works – in Badakhshan, Bamyan, and Baghlan. The WASH program of UNICEF in the western region has trained teachers in hand washing so they will pass this on to their students, but it has been difficult to document behavior change results. These programs all work with provincial Directorates of Education (DoE) and staff of the selected schools. However, according to the DoE in Herat, schools are reluctant to actively collaborate in programs like these unless they are sponsored through the MoE.



**Figure 5: A girls' classroom in a school in Faizabad, Badakhshan**

UNICEF is working with the MoE to plan an adolescent nutrition program that will commence in 2015 and will focus on including some nutrition messages in secondary and higher curricula. It will focus first on in-service training and later on introducing the program in teacher training institutions. This reflects a shift from focusing on emergency treatment to development and involves a multi-sectoral effort to address stunting. Following decades of fighting, the education system requires tremendous reconstruction as well as upgrading. Many buildings have been destroyed and untrained teachers are passing on basic literacy and numeracy skills in many areas. One person commented that new, young female teachers bring enthusiasm to their classes, while in boys' schools many (male) teachers appear to be old and rather tired.

Yet, surely opportunities abound for disseminating knowledge and reinforcing healthy habits through school programming. A man the Team Leader interviewed in the Herat DoE remembered a course on healthy habits and good manners from his school days under King Zahir Shah (pre-1973), but that no longer exists. Nutrition is not integrated into the curriculum, especially at the primary level, where the greatest number of students is enrolled. Likewise, it is barely integrated into teacher training programs, and professional teachers are reluctant to serve in rural districts, so dissemination is limited. The education ministry has no in-service update training programs, although some are offered by NGOs to a limited number of teachers. The Afghan Institute of Learning boasts of training thousands of teachers, but based on a discussion at its Herat office, the vast majority of these courses are only two weeks in duration.

## 8. WASH

Water, sanitation, and hygiene are little-recognized as key contributors to the repeated episodes of disease that lead to acute malnutrition and stunting among young children. Even team members found it unpleasant to discuss the toilets they had observed and wished to move to less-offensive topics. Most families have traditional pit latrines inside the walls that define their home. Typically, a small pile of stones is placed on one side of the hole, and after being used for cleaning after defecation, stones are placed on the other side; later, they are replaced with clean stones. Frequently, the latrines are located close to simple wells of undetermined depth, thus very likely contaminating drinking water where the water table is high. But aside from a few in Kabul who complained that after boiling, water develops a frothy scum, people throughout the country believe think their drinking water is of good quality. Among the very poorest, some lack even basic latrines. Instead, women use a large can of sand inside the house, possibly close to the area used for cooking, as that is relatively private. When necessary, the sand is thrown outdoors and replaced with clean sand.

A cow and some free-roaming sheep, goats, or chickens are often kept in a rural compound. The cow manure is patted into flat rounds and stuck on a wall to dry – this processed straw is a good, slow-burning cooking fuel. Rarely, excreta are collected and used as fertilizer. Open defecation is very common too, especially by men when they are outside their homes. A cluster of small trees between a compound wall and the river in Faizabad was regularly used



**Figure 6: A latrine located in a compound in Sangar Sari, Nangarhar. Squat toilets such as these are typical in rural areas.**

by men, but few were aware of the source of the mild aroma when they sat on the outdoor plaza at the adjacent hotel in the evening.

The Ministry and Provincial Directorates of Reconstruction and Rural Development (MRRD, DRRD) administers the National Solidarity Program (NSP). This sponsors male and female *shuras* in each village, and mixed-gender *shuras* at the district level. *Shuras* prioritize three projects and prepare proposals for funding by donors. Some funds are available from the government, and villagers are expected to provide all required labor for construction. Their environment committees are responsible for maintenance. 200 water supply projects have been funded through this program (as well as sanitation with UNICEF support, local handicraft improvement with UNDP support, road, electricity, and other local projects). After testing water quality, large 100 meter-deep wells are dug and water piped to houses. (In rural areas of Herat province there is too much salt in the water.) Ten percent of subsequent annual budgets must be reserved for maintenance of pumps and the high standard filters they use.

UNICEF works with the MRRD and the MoE with both hard and soft programming. In communities, it helps construct water points and piping, builds demonstration latrines, and disseminates hygiene messages. It also trains local masons at the village level to build of sanitary latrines that are odor-free and generate fertilizer. CHWs have the added responsibility of promoting hygiene and may receive a daily incentive of 100 to 150 Afs (\$2 to \$3) for this work. In schools, UNICEF also build water points, sanitary latrines, wash rooms for girls, and hand washing facilities. It trains teachers, including on hygiene, and tries to get WASH included in the curriculum. Only in two model schools in Herat, however, has WASH been incorporated into the education program.

UNICEF convenes quarterly meetings, performs random checks of school facilities, and distributes toolkits for making minor repairs. It is piloting a solar-powered water pumping scheme. Since there are no immediate results of improved water supply, sanitation, and hygiene, people often do not perceive the value of these efforts. After many years of promoting sanitary latrines and training local men to produce concrete slabs, UNICEF is piloting Community Led Total Sanitation (CLTS) in two districts in the western region. Key to this approach is a “walk of shame” in which residents and a facilitator tour the community and point out and comment upon feces and other waste lying on the ground. In the same region, World Vision is experimenting with ventilated improved latrine (VIPs), building demonstration latrines, and providing cement and other materials for construction. These toilets reportedly create fertilizer through a composting process.

#### **a. Hygiene**

Respondents often stated they wash their hands regularly, but sometimes team members reported that despite their verbal report, their hands looked as though they had not been washed for a month. Some children were told by their parents to say they wash frequently. Others were apparently more honest, stating they wash their hands in the morning and evening, or before serving food. The question lists included the prompts ‘after using the

toilet' and 'before eating,' but team members might have mentioned these along with the initial question – a surprisingly large number said they wash at these times.



**Figure 7: A typical handpump used to fetch water for cooking and washing hands**

The typical place for hand washing is at the hand pump in the compound. Otherwise, water stored in large plastic bottles may be used. Some people mentioned the bottles have covers, but they often appear to be very dirty, at least on the outside. In some urban homes of better-off citizens, there are sinks with soap on them, but sometimes these are reserved for guests.

## **b. Waste Management**

Waste management is a serious problem throughout the country. Major cities have trash points where local residents and men who are paid to collect trash from peoples' homes in wooden carts dump all manner of waste and scavengers come to collect items to sell. The piles are often very large and abuzz with flies.

Waste water is generally thrown on the ground, in or outside the compound, or into the street. Paper is usually burned. Plastic is also often burned in *tandoors* (clay ovens), infusing bread with dioxin.<sup>8</sup> In Badakhshan, trash of all kinds, including used diapers and toilet paper, is thrown into the river. One brief mention was made of composting garbage in Herat.

## **9. MEDIA**

The walls of health centers are liberally decorated with myriad posters on nutrition and maternal and child health, but it is unclear how illiterate women and men perceive the images. Can they discern a mother and baby amid the lines and color without having looked at picture books as children, or do they need someone to patiently discuss each picture in

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<sup>8</sup> Dioxin is one of family of persistent environment pollutants found throughout the world. They accumulate in the fatty tissues of animals and thus enter the food chain. They are highly toxic to humans and cause reproductive and development problems and damage the immune system, interfere with hormones and cause cancer. World Health Organization Fact Sheet No. 225, "Dioxin and the Effects on Human Health" updated June, 2014.

order to grasp their meaning? Many convey similar messages and most are posted high on the walls, in part because the lower walls are often made of concrete. Even the connotations of various colors might need to be explored, recalling the significance to patients of the color of iron pills.

Women are sometimes forbidden to watch television, in the limited areas where it reaches, because men fear contaminating influences. But where it is available, many watch a long-running Turkish serial called *Fareha* in which the husband treats his wife very well. No doubt this grabs the heart strings of many an isolated woman in this society, leading her to a dream world where she is respected and cared for.

Radio is far more widely accessible to both men and women and many listen to a program entitled *New Home New Life*. This is a family drama that has been running for 16 years. Included in the plot are decisions about family size, treatment of illness, and the roles of men and women in society.

The success of these programs suggests that an Afghan TV drama that appeals to both men and women and that addresses issues of the family and social change might be a very effective modality for conveying information about maternal and child health and nutrition. Some men stated that they watch sports on TV so a protagonist who plays football and/or cricket might be appealing to men.

There is a national mobile phone line to which one can dial to hear health messages, and WVi is considering use of mobile telephones for training health workers. Satellite-based communications such as those employed by AKDN and FMIC to support telemedicine suggests possibilities for the eventual provision of distance learning in schools and for community groups.

## **10. VARIATION AND CHANGE**

Many families are migrating to Kabul and other cities in Afghanistan due to destruction of rural infrastructure during the recent decades of fighting or to ongoing security risks related to Taliban control in many rural areas. Many migrants are uneducated and lack resource, so they often encounter great difficulty in the cities. They rapidly abandon the simplest of rural practices, not growing a tomato in a pot or keeping a few chickens in their yard. And no longer do they dry meat and vegetables for the winter. Instead, they depend entirely upon the cash economy. Groups of men gather on street corners hoping to be chosen to labor on someone's project for the day. Others, especially if they have connections, may find work as guards. Driving is a skilled job upon which only so many can rely. As throughout the country, the need for jobs is extremely pressing.

Mountainous areas in remote locations present particular challenges. The climate is rugged, transportation and communications often very difficult, and the costs of material (including food) and service provision higher. Well-educated citizens are reluctant to stay for long periods in such places, so upgrading education and health care is more difficult than in more accessible areas. Despite, or perhaps due to, such problems, residents of Badakhshan (near

Faizabad) were more open to educational opportunities for girls. In small communities where everyone knows everybody else, women's mobility may be somewhat greater than in crowded urban areas where it is harder to identify offenders.

By contrast, Herat is influenced by its proximity to Iran and by the fact that many moved there during the fighting. The language is closer to modern Persian and stylish detail is seen in the embroidery on men's shirt fronts and in such architectural features as window styles, compound gates, and recessed ceilings. Nangarhar and especially Kandahar are very conservative and influenced by Pakistan, especially the Pashto-speaking areas to which many fled as refugees. It was not safe for women team members to go out without burkas in Kandahar, and a number of the worst tales of violence against women were from there. One woman in the focus group showed her face in the group photograph, saying she did not care if she were killed for the offence.

Among well-educated urban families, change appears to be taking place fairly rapidly. Women are being educated at the university and working in increasingly demanding jobs, but this opportunity still would not exist if their fathers, in particular, did not grant permission. On two occasions, one in a home and another in a clinic, teenage daughters dared to openly complain in front of mothers and outsiders that they were being treated unfairly in comparison with their brothers. This suggests that new ideas about gender equity and personal liberty are reaching the younger generation.

#### **IV. CONCLUSIONS**

##### *Cultural Traditions*

Cultural traditions, of both family and religion, have provided stability in Afghan society for centuries. In this patrilineal and patrilocal culture, males embody the family identity and women are brought into the home to produce the next generation of men. Generally considered a burden from birth until she is married, a girl is expected to toil under the stern gaze of her mother-in-law and first gains respect when she has a son, upon whom she therefore dotes. She is held responsible for her failure to get pregnant, for having daughters, and for the ill-health of her children, and may be punished both physically and psychologically for these. When her son marries, she attains some real power and replicates the treatment that she received when younger. A boy becomes a man when he marries and is welcomed in discussions among men in his community. Thereafter, he is judged by the behavior of his wife and children and subject to great social pressure to conform with shared norms and an accepted interpretation of Islam.

##### *Power Dynamics*

Power is largely based on ascribed status. Sex and then age are the primary determinants of a person's status, but family history, economic status, education, personal qualities, and reputation also influence one's position. (Male) elders meet in a *jirga* to decide on matters of

shared interest and thus have political power within a community. The *mullah* and to some extent teachers are respected and exercise moral authority. Economic opportunity and potential wealth are most accessible to those with funding and the connections that facilitate access to good education and jobs. Physical power is seen in surprisingly common wife beating, abuse of young boys by pederasts, and sometimes in the treatment of young women by their mothers-in-law. Passive aggression and other psychological abuse may be used by women within the home and in the form of social pressure to compel conformity among men.

### *Foods and Feeding Practices*

Men do the shopping and often list vegetables, fruit, meat, etc. when asked about foods for pregnant and lactating women, but women frequently mention daily food or whatever is available. Thus, in contrast with the West, men are the ones who choose what the family will eat. Also, women can neither attend programs without their permission nor implement behavior changes in the home without their support. Educating men about nutrition is of paramount importance.

Qualitative categories of food are often used, such as hard, soft, strong, and energetic, and being plump is evidence of health while a thin person is said to be weak. Though not articulated, the humoral concepts of Galenic-Islamic (Yunani) medicine appear to influence selection of foods. Meat was never recommended for pregnant women, possibly because it is heating and might further upset the balance in a woman already heated by a fetus, but meat and eggs as well as chicken soup are necessary after delivery perhaps to restore lost heat and to regain strength. Unaware of physiological processes, people consider extra liquids and to some extent sweets to be important for production of flavorful milk. The liquids might also be thought necessary to prevent the mother from becoming too dry in the humoral sense. Advice that vegetables and fruit are good for you may be understood to mean that they are strong and thus likely promote weight gain.

Most people say they give colostrum to babies, but organizations that work in communities report that many believe it is spoiled milk that has stayed in the breast too long and give tea, butter, and water in a cloth for the baby to suck on. Powdered milk or formula is mentioned by very few for feeding in the first few months, but midwives feel a campaign to counter its appeal is needed. Mothers vary widely in the number of times they breastfeed their babies each day, some saying as few as two or three times. Though about ten percent think they should wait until the baby is one year-old, most say that they start babies on soft foods after six months. By one year, many children are being given the same foods as adults. Men are most likely to mention vegetables and fruit as good for babies.

### *Health Services*

Clinics appear reasonably clean and the walls are decorated with posters from various agencies. Stockrooms appear full, but resupply is sometimes difficult. Inadequate numbers of female health workers is a serious problem throughout the country. Lack of a shift system

means very long hours for midwives, who may delivery up to 70 babies a week; and unavailability of a substitute if they must leave for a family emergency may put women's lives in danger. In some areas, vaccines are believed to sterilize children and vaccinators may be cursed for trying to do their jobs and face serious challenges to meet their targets. Illustrated flipbooks are used for health education, but no staff member has nutrition education in his or her TOR and no place is set aside for education in most clinics.

People the assessment team spoke with complained of poor attitudes of health staff and being charged for consultations and/or medicine Constraints on women's mobility due to the requirement that many get permission from their husbands or mothers-in-law to leave the home, and due to the long distance they must often travel, delay treatment and contribute to less-than fully satisfactory outcomes. Community-based health care is through FHAGs that are supposed to note emerging health problems, and CHWs who may provide basic treatment or refer patients to clinics before problems worsen. They have the best chance of reaching people in villages, but they are volunteers, and more tasks are added to their list of responsibilities with each new program.

Because men are the decision makers in families, failure to educate them about health and nutrition requirements of women and children means that women are unable to act on the advice they receive in many trainings. Mobile teams visit communities from time-to-time (when funding is available) to address women's health. Lack of men's health screening programs means missed opportunities to motivate them to participate in training programs that could lead to better health and nutrition practices by everyone. Men-to-men communication is necessary.

People judge the quality of care and the practitioner from whom they receive it by the presumed power of the treatment: syrup, tablets, and capsules are the least powerful, followed by injections, X-rays, and ultimately intravenous drips. As with foods, concepts from Greco-Islamic medicine appear to operate in health. Overeating meat, which is considered to be heating, may cause fever, and consuming cold water or ice cream may cause sore throat. People also expect to be advised about foods to eat or avoid when taking supplements or medicines, apparently believing that their humors may be thrown out of balance by strong, 'hot' medicines and create further problems. The color of pills may be off-putting and care should be taken to make sure the packaging materials appear healthful. Local beliefs, for example in Badakhshan that eggs, meat, and grapes (rather than lack of iodine) cause deafness, may be known to health workers. Belief that jinns cause mental illness and seizures is widespread, leading people to fear and shun the afflicted rather than provide support.

### *Nutrition Programs*

NGOs implement BPHS programs in the provinces. The nutrition component has not been given adequate priority in these programs, partly due to a lack of capacity of the designers and bidders and partly to the cost of these programs. BPHS bids which included fully-funded nutrition components would not have succeeded in the competition because 25 percent of the

evaluation score was based on cost.

Many of these programs have created health *shuras* (committees) with each clinic, but only the AKDN convenes compulsory monthly meetings with these groups to ensure that the program is accountable to the people it serves. Its program works holistically with communities, integrating nutrition, hygiene (including teeth brushing), community cleanliness (through school programs), fortification of flour, agricultural initiatives and microfinance development. Its nutrition programming includes counseling and provincial forums on pregnancy and lactation; iron and folic supplementation; group monitoring; vitamin A for postpartum women; exclusive breast feeding to six months; complementary feeding; and diarrhea and parasite control. It is preparing a book on Islam and hygiene in conjunction with the MoHRA, and can link its clinics to expert care through telemedicine.

The BDN program in Herat includes psychological counseling in its program. STC includes nutrition programming messages in several provinces with its BPHS program in Kunduz. It runs a prevention-oriented antenatal program and meets quarterly with *mullahs* to discuss foods and hygiene. The PNO and DoPH in Badakhshan has sponsored training for doctors and health workers on women's needs for iron and folate, and trained three teachers from schools throughout the province during nutrition week.

The most successful nutrition programs build on positive deviance – finding poor women whose children are well-nourished and asking them to share their ideas on feeding and child care with others. These are run by STC and WVi. Whether referred by health centers where severely acutely malnourished children may be treated, or identified through screening programs to identify moderately acutely malnourished children in villages, communities are mobilized and groups of women meet to cook together and also receive health and nutrition information. First, STC offers an orientation session to the men and then it trains CHWs and FHAG members to implement the two-week long program. Women bring available foods and learn to prepare high-nutrient density meals together. In the World Vision program, facilitators demonstrate different meals for ten days also using locally available foods before women prepare them. Participants see children start to gain weight very quickly and STC staff members follow up on the children's progress. These and other organizations also have additional nutrition treatment and education programs on breastfeeding, complementary feeding, and IYCF.

WFP, WHO, FAO, and UNICEF have a range of nutrition programs from school lunches and treatment for MAM, to growth chart distribution, to school gardens and greenhouses. WHO is developing indicators for monitoring government feeding programs. UNICEF conducts community mobilization to raise awareness, screens children under age five, counsels their mothers, disseminates IYCF communications, provides micronutrient powder for six to 23 month-old babies on an emergency basis, and airs TV and radio spots about breast feeding, complementary feeding, and maternal health. In 2015, it is planning an adolescent health program with iron supplementation through schools and will add nutrition officers in each of its five regional offices.

## *Agriculture*

Men grow field crops, which women help tend and harvest. Most of the produce is sold through middlemen who take outsized profits, revealing the need for cooperative marketing mechanisms for groups of farmers. Women are primarily responsible for livestock except when animals are taken out to graze. In Herat, they separate saffron from crocus blossoms and grow some poultry for the market, but have virtually no control over the businesses or income earned.

FAO sponsors school and home gardens in communities, but monitoring is the responsibility of various provincial directorates that may not have the budget to carry this out. In the western region, WVi distributes materials to 3,000 women for cold boxes and for five greenhouses at the health center level. It supplies incubators and one round of eggs, food, and vaccines for hatching chicks to groups of 40 women, each of whom will raise ten after they hatch. They are training the women to vaccinate but future supplies of vaccine will depend on DAIL.

NEI is developing the full value chain of soy production. Farmers in many areas have been growing soy for a few years and continue to provide inputs and purchase a large share of the crop. They make and donate soy milk and give seeds and flour to women who complete a training program on cooking both soy korma and part-soy bread. The training is cascaded first to 25 teachers in a district and each of them is expected to train 40 others.

AKF is supporting diversification in agriculture by introducing climate-appropriate hybrid seeds, providing materials for greenhouses for off-season vegetables, and helping to construct simple underground cold storage facilities. Its poultry SME development program was based on careful value chain research and has been very successful. Over 70 percent of the 3,000 members of a savings groups for agriculture-based businesses are women.

## *Education*

Many programs target activities through schools, but administrators are reluctant to support programs that are not sponsored through the MoE. Many schools have been destroyed in recent decades, curricula do not integrate health and nutrition, teacher training programs have not been updated, and in-service training is not provided except by some NGOs. Professional teachers are very reluctant to serve in insecure rural areas, so untrained teachers are disseminating basic literacy and numeracy in many areas.

## *WASH*

WASH is a largely overlooked cause of infant and child malnutrition. Though some in Kabul complain that after boiling, water develops a frothy scum, people throughout the country believe their drinking water is of good quality. Most people also have pit latrines in their compounds, but these are often very close to wells and may be contaminating the water.

Open defecation is common, especially among men when outside the home. Livestock leave manure on the ground in compounds as well as outside. The DRRDs manage the NSP, under which communities prioritize up to three key projects and seek support from donors. They also support a range of infrastructure and income generation projects and have built deep wells where they locate good water. These include pumps, filtration systems, and piping to surrounding homes; local environment committees are in charge of maintenance and require ten percent of the DRRD budget for this annually.

UNICEF has been supporting WASH for years, building demonstration latrines and teaching masons to construct odor-free, fertilizer-producing models, and supplying materials for their construction. UNICEF disseminates WASH messages in communities and schools, where they also build water points, latrines, and hand washing facilities. Its efforts to have WASH included in school curricula have only succeeded in a few model schools. The agency is piloting CLTS in a few communities in the western region, hoping that calling public attention to local contamination will motivate people to invest in and use latrines. WVi is also testing VIP latrines, which likewise are odor-free and create fertilizer.

Many respondents said they wash their hands regularly, but evidence to the contrary was clear. People may rinse their hands under the pump in the yard, use water that has been brought and/or stored in large plastic bottles, and the better-off may have sinks and soap in their homes.

Waste water is typically thrown on the ground or dumped in a well. Garbage composting was mentioned only once; paper is burned, as is plastic, often in the tandoor and thus infusing bread with dioxin. In cities, water may be thrown into the street and other trash taken to trash points for eventual pick up.

### *Communications*

IEC materials are disseminated through posters in clinics, training programs, radio and TV spots, and some by cell phone. Radio reaches much wider areas than television, and news, music, family programs, and some sports are popular. A very popular, long-running radio program created by the BBC focuses on families as they deal with social change, including health and nutrition issues. A Turkish television serial about a family in which the man treats his wife very well appeals greatly to women. It appears that there is potential for an Afghan TV soap opera that addresses family structure, social change, non-violent conflict management, and maternal and child health.

### *Regional Variation and Social Change*

While regional differences remain marked, urban Afghanistan is changing. Refugees are returning from other countries where they have been exposed to alternative ways of organizing social life, and many are coming from rural areas where infrastructure and land have been badly damaged by years of fighting. People very quickly abandon home production – there are no potted tomatoes or chickens in a yard, and people no longer were

seen to dry meat and vegetables for the winter. Instead, they rely on often insecure jobs to earn cash. Education levels are increasing, and especially among well-established urban families, some women are also moving into professional employment. The average age of marriage is slowly increasing, and having some say over the choice of one's marriage partner is beginning. Largely due to great economic pressures, family size is also beginning to fall somewhat and some health care messages appear to be internalized; for example, many are aware that prescription medicines should be avoided or taken only with the advice of a doctor when a woman is pregnant.

## V. RECOMMENDATIONS

### *Community Level Nutrition Programming*

- Work with the MoHRA to ensure *mullahs* are informed of any new programming and for approval of new ideas disseminated.
- Work with men first because women cannot participate in training programs or other activities without their permission, and are unable to implement behavior change within the home without men's support.
- Start with the *malik* or *wakil* and the elders, as they are the opinion leaders.
- Meet with other key stakeholders: the local *mullah*, members of health *shuras*, and members of community development committees.
- Offer to help men fulfill their important responsibilities as Muslims to care for their families by sharing information that will improve their children's health.
- Meet and assess possibilities for involving / offer to work with CHWs, FHAG members, and teachers, to recognize their roles and enhance local respect for their work.
- Consider expansion of mobile health teams to include men's health days with screenings and basic treatments, and engage men in education programs.
- Employ male educators when speaking with men about reproductive health.
- Teach men first to demonstrate respect for their position as decisionmakers because they do the shopping and choose the foods that are cooked and eaten at home and because most of them are better-educated than women. Make them comfortable that the content is not in any way contaminating and they will grant permission for women's participation in subsequent activities.

- Employ concrete examples in all IEC. For example, to encourage child spacing, give the example that if carrots (or whatever crop is grown locally) is planted too close together, individual plants will be small (and/or produce limited grain/fruit/etc.), but if they are spread out they become big (or are more productive).

### *Women's Community Nutrition Programs*

- Create group-based activities and locate activities for women within easy walking distance of their homes and in places where they are shielded from public view.
- Go beyond teaching and demonstrating – beyond telling and showing – to engage people in the hands-on learning that is necessary to introduce behavior change among adults and among predominantly illiterate populations.
- Consider seeking out examples of positive deviance, reinforce existing good practices, and promote sharing of information and practices by women.
- Employ locally available and affordable materials. In cooking programs, teach women to preserve vitamins by not cooking foods at too high a temperature.
- Follow-up with each community in the short- and medium-terms to verify adoption of new practices and address any issues that may have arisen.
- Include information to counteract the appeal of powdered milk and formula for babies in nutrition education programming.

### *Health*

- Work with the MoPH and medical training institutions to incorporate in the curriculum modules on both nutrition and 'bedside manner' to improve practitioner attitudes and encourage them to listen carefully, even when people employ models of the body and illness that differ from how they are trained.
- Promote shift scheduling and availability of substitutes so that health workers can get regular rest and do not leave clinics understaffed in the event of a necessary absence.
- Support rights-based approaches to dealing with gender-based violence, sheltering victims, and enforcing punishments for perpetrators.
- Support development of community nursing programs to upgrade community-level care giving.
- Promote family counseling (a woman plus her mother-in-law and/or husband) for family planning so all learn about the methods simultaneously.

- Assess public comprehension of the posters that are liberally distributed to clinics, and also post them in markets and government offices to reach a wider audience.
- Support development of local radio and TV program(s) or serial(s) that incorporate attention to mother and child health and nutrition, as well as try to change Afghan family and social norms and behaviors.

### *Education*

- Work with the MoE in all initiatives related to education to ensure their support within schools.
- Promote the incorporation of nutrition information in curricula for students at multiple levels, and for teachers both in training and in service.
- Assist with the development of appropriate teaching materials and linking educational activities for children with good practices, such as sprouting seeds in class or planting and caring for a tree in the school yard, practicing hand washing, collecting recyclable plastics during community clean-up days, etc.

### *Agriculture and Livestock*

- Introduce cold boxes for senior men as well as women and greenhouses for local groups. Offer demonstrations and hands-on learning programs to promote off-season production, consumption, and sales of vegetables.
- Through radio and TV spots and possibly school programs, promote urban gardening in yards or in pots to support better nutrition.
- Support installation of solar water pumps for irrigation (and other uses).
- Disseminate post-harvest storage facilities, including simple underground cold storage where feasible.

### *WASH*

- Advocate for and support expansion of CLTS programs to address severe sanitation problems and the diseases to which they contribute.
- Consider promotion of odorless, fertilizer producing VIP latrines.

- Promote production and distribution of affordable, easily-maintained water filtration systems for drinking water.
- Support solar water purification systems for appropriate locations (and other applications). If a woman can sew, she can solder, provided there is good ventilation, and can learn to install wiring inside homes, while men could be employed to install external solar collectors on buildings and homes.
- Promote recycling of plastic bottles to make boxes for shipping produce and other items.

### *Overall*

- Be extremely careful to avoid inappropriate promises – unmet expectations very quickly lead to disillusionment and undermine motivation to contribute .
- Actively promote adoption of results monitoring in all programs and assign responsibility for it. Provide necessary support for it on an ongoing basis.
- Provide or secure a long-term commitment to supporting all activities.
- Build on one activity to support another initiative – for example, offer to assist women who took part in a cooking program with home gardens the next year.
- Integrate the health, education, agriculture, and WASH dimensions of nutrition programming within communities to optimize clearly demonstrated results.
- Require community contributions to any construction project or other activity.
- In all activities, give local people time to express their ideas and ask questions. Listen carefully to what people are trying to say, including when they are thinking about a problem or issue in a very different way.
- Work with existing *shuras* or established groups with specific responsibilities related to a new initiatives. Coach groups on staying focused on their tasks to enhance their effectiveness by reducing friction that may easily develop when aims are not clear.
- Promote regular meetings of local *shuras* or other groups to ensure that activities are accountable to local people and are therefore more likely to be sustained.

## **ANNEX I: SCOPE OF WORK**

### **OFFICE OF PROJECT AND PROGRAM DEVELOPMENT (OPPD)/ OFFICE OF SOCIAL SECTOR DEVELOPMENT (OSSD)**

#### **STATEMENT OF WORK (SOW)**

#### **GENDER ASSESSMENT OF THE SOCIO-CULTURAL DETERMINATES OF NUTRITION IN AFGHANISTAN**

### **I. INTRODUCTION**

Since the fall of the Taliban there have been significant successes as a result of the Government of the Islamic Republic of Afghanistan (GIROA) stewardship and donor assistance. Despite such progress, much remains to be done. Instability persists throughout much of the country and confidence in GIROA is fragile. Facing international military drawdown and declining donor assistance, Afghanistan is transitioning to a period characterized by greater Afghan ownership of security and development objectives beginning with the current transition year (2014) and lasting through the Transformation Decade (2015-2024). Over this period of transformation, GIROA will have to take the principal role in addressing the development challenges in Afghanistan. The challenge moving forward is to strengthen GIROA's capacity to continue achievements realized over the past decade years.

Afghanistan has some of the worst nutrition indicators in the world. Roughly 7.6 million Afghans (30 percent of the population) are food insecure and one in three children under the age of 5 is underweight. Recent data suggests food insecurity has worsened over the last few years. While there are regional differences, two-thirds of Afghan households do not consume diets with sufficient food diversity. Vulnerable groups, such as the poor, women and children, internally displaced people and returnees, are the most food insecure. Nutritional status is affected by more than just the availability, access, and consumption of foods. Nutrition levels are directly impacted by hygiene and sanitation practices, disease prevention and repeated treatment courses and protocols, as well as the varied geo-specific socio-cultural norms found in Afghanistan.

More than half of Afghan children under the age of 5 are stunted (60.5 percent). Stunting (low height for age) occurs early, during pregnancy and the first two years of life of a child, by age five; stunting is irreversible and also has detrimental effects on the child's emotional and cognitive development or being able to reach its optimal potential to live a productive and quality life.

Stunting is caused by chronic deprivation of nutritious and appropriate foods coupled with repeated bouts of illnesses, infections, or/and episodes of severe malnutrition. Preventing stunting by focusing on the first 1,000 days of life (from conception through a child's second birthday) is key for Afghanistan's human and economic development. Nutritional deficiencies lead to increased morbidity and mortality, as well as substantial economic losses in countries with high prevalence of malnutrition. More than one-third of all deaths among children under five worldwide are attributed to malnutrition, and the World Bank estimates that many countries lose at least two to three percent of their Gross Domestic Product (GDP) due to malnutrition. Furthermore, it is recognized that without reducing childhood

malnutrition, developing countries such as Afghanistan will not be able to achieve the first of the Millennium Development Goals (MDGs), i.e. to eradicate extreme poverty and hunger.

To maintain the social and health gains made in the last ten years, and to enable continued economic growth, Afghanistan must tackle the issues of acute and chronic malnutrition through coordinated, multi-sectoral approaches to address factors contributing to malnutrition including policy and economic factors as well as direct determinants of nutrition such access to food and caring practices.

Nutrition encompasses many varied sectoral and has a strong relationship with Gender inadequacies as documented the Gender and Nutrition Issues Paper by FAO 2012:

Gender and nutrition are inextricable parts of the vicious cycle of poverty. Gender inequality can be a cause as well as an effect of hunger and malnutrition. Not surprisingly, higher levels of gender inequality are associated with higher levels of undernutrition, both acute and chronic undernutrition.

Gender and nutrition are not stand-alone issues; agriculture, nutrition, health and gender are interlinked and can be mutually reinforcing. Some experts consider women to be the nexus of the agriculture, health and nutrition sectors. Gender and nutrition are increasingly acknowledged by the development community as important cross-cutting issues. Recently, the reciprocal relationship between the two issues was affirmed, giving rise to various efforts that seek to mainstream gender into nutrition policy and programming.

While diverging interpretations of gender exist, there is a common understanding that women and men should have equal rights and opportunities. Women continue to face discrimination and often have less access to power and resources, including those related to nutrition. This underscores the need to apply a rights-based approach to gender programming, with opportunities to leverage complementary rights-based nutrition principles such as the Right to Food.

Therefore USAID is looking to have a gender assessment for the socio-cultural determinates of nutrition, to produce a set of recommendations to inform the development of future USG projects addresses malnutrition in Afghanistan. These findings and recommendation of this requested assessment will be used to complement the gender analysis in accordance with USAID's Project Design Guidance and ADS 201.3.15.3. USAID and will also assist in determining resource allocations and recommendations to the Ministry of Public Health (MoPH), other donors and stakeholders regarding nutrition programming in Afghanistan.

## **II. PROPOSED PROJECT BACKGROUND**

Women in Afghanistan continue to face discrimination and often have less access to power, decision making processes and resources that directly affect their lives, including those related to nutrition. This underscores the need to apply a rights-based approach to all development programming, to exploit opportunities to leverage complementary rights-based nutrition principles such as the right to food.

There is a strong relationship between gender-based discrimination and the different channels through which households and individuals access food—through own-production, food utilization (what to cook), access to waged employment, or social protection. The roles, priorities, needs and use of resources may differ between men and women. The tendency is to

focus on women when addressing gender, yet this overlooks the instrumental role of men in closing the gender gap. Both men and women need to be involved in this process, acknowledging their respective roles and needs, and fostering mutual awareness and partnership.

A number of gender-related factors may affect nutritional status in Afghanistan. Because of social traditions men and boys may be favored, and therefore better fed, than women and girls. Women may face constraints in accessing social and health services, including food, as a result of insecurity, cultural discrimination and limited mobility. Women, especially those who are pregnant or lactating, may be disproportionately affected by under-nutrition due to their increased physiological requirements especially as they have no reserves because of their own chronic malnourished state or even stunting. Teenage pregnancy exacerbates and can lead to poor health and nutritional status for both the baby and the mother. While remaining the main caretakers of children and other dependents within a household, women may take on additional activities to support household food security, especially in situations where male heads of households are absent. This often leads to disruption in infant and young child feeding practices and reduced caring capacities. And finally, single men and boys separated from their families can be at risk of under-nutrition if they do not know how to cook or access food distribution.

Further proposed programmatic interventions will deal with and complement ongoing USAID nutrition-related activities and contribute to the USAID/Afghanistan Nutrition Implementation Plan 2014-2018. Together, the new suggested interventions and already approved nutrition-related activities is hoped to help reduce stunting in Afghanistan by five percent. New interventions will specifically target the “first 1000 days” which includes pregnancy and the first two years of life. The decision to target women, adolescents and children under two is based on findings from the Copenhagen Consensus (2008, 2012) on the best investment buys for development. Key, direct nutrition interventions, particularly targeting pre-school age children, ranked as the top investment priority to confront the world’s most important development challenges. According to the summary report of the 2012 Copenhagen Consensus, “... even in very poor countries and using very conservative assumptions, each dollar spent reducing chronic malnutrition has at least a \$30 payoff.”

Proposed interventions are intended to work through and strengthen existing host country systems in order to improve the reach and effectiveness of other donor nutrition interventions carried out by targeted ministries, the private sector and local organizations. Investing in the capacity of Afghans to prevent and respond to malnutrition is critical to the sustainability of USAID nutrition interventions. USAID will focus these new interventions on generating demand for nutrition services and contributing to changed behaviors critical to improve feeding and hygiene practices in targeted communities. Thus, USAID needs to identify a baseline that will ensure USAID is practicing evidenced-based decision making to understand and address the causes of malnutrition especially within a gender lens in Afghanistan.

### ***Health and Nutrition***

World-renowned economists have investigated the evidence on the best investment buys for development, publishing their findings as The Copenhagen Consensus (2008, 2012). Key direct nutrition interventions, particularly targeting pre-school age children, ranked as the top investment priority to confront the world’s most important development challenges. According to the summary report of the 2012 Copenhagen Consensus, “... even in very poor countries and using very conservative assumptions, each dollar spent reducing chronic

malnutrition has at least a \$30 payoff.” Recent updates from The Lancet/UNICEF *2013 Maternal and Child Nutrition Series* indicate that acceleration of progress in nutrition will require effective, large-scale nutrition-sensitive programs that address key underlying determinants of nutrition and enhance the coverage and effectiveness of nutrition-specific or direct nutrition interventions. The bundle of high benefit-to-cost interventions include provision of vitamin and mineral supplements and fortified complementary foods to young children, de-worming and diarrheal disease treatment, and related behavior change communication.

More than half of Afghan children under the age of 5 are stunted (60.5 percent) and cannot fully reach their developmental capacity either physically or mentally as they should because of chronic nutritional deficiency. Children in the poorest communities are more than twice as likely to be stunted compared to children from the richest communities. Stunted children are also more likely to contract diseases and lack access to basic health care, and to not attend school. Adolescent girls who are stunted are more likely to give birth to babies who have a higher chance of becoming stunted, higher morbidity and mortality. Stunting of young children occurs early, during pregnancy and the first two years of life of a child, by age five, stunting is irreversible. Preventing stunting by focusing on the first 1,000 days of life (from conception through a child’s the second birthday) is key for Afghanistan’s human and economic development.

GIRoA’s ability to provide services to the population effectively, especially in health and education, is crucial for the government’s legitimacy and, ultimately, lasting stability. To maintain the social and health gains made in the last ten years, and to enable continued economic growth, Afghanistan must tackle the issues of chronic malnutrition through coordinated, multi-sectoral approaches to address factors contributing to malnutrition including policy and economic factors as well as direct determinants of nutrition such access to food and caring practices

### ***Gender***

As USAID/Afghanistan embarks on the transformation decade and a new ten year strategy, the role of women remains is critical. Throughout the world, women’s empowerment is inextricably linked to security, economic opportunity, effective governance, and social development. The political and financial realities of transition threaten the preservation and expansion of women’s rights in Afghanistan. Investments in women are the single most effective poverty alleviation mechanism contributing to a society’s prosperity; conversely, lack of investment characterizes failed states.

Four factors combine to make intensive and sustained attention to Afghan women both urgent and compelling: a) GIRoA transition by 2015; b) the still-fragile status of Afghan women; c) the yet-unrealized development potential of 50% of the population; and d) their relative absence from Afghan government and international security and development plans. In Afghanistan, the gender-based disparities of access to health service and other resources are well-documented. Afghan women’s traditional role and status render them less visible and more difficult to reach through common communications outreach practices. They have a lower level of education, are less aware about health rights, are less mobile within their communities and country as well as abroad, and are exposed to gender-based discrimination and harassment.

Although circumstances for Afghan women and girls have improved significantly since 2001, gains remain tenuous. The USG and other donors must continue to prioritize protecting women and promoting women's rights in Afghanistan in order to ensure that the positive gains are irreversible. For this reason, "Advancing the Rights of Afghan Women" to ensure the sustainability of current gains in women's rights and expand the economic potential of Afghan women has been emphasized in many USG policy and strategy documents. One of the overarching outcomes of USAID's investment under the *USAID Gender Equality and Female Empowerment Policy*, March 2012, is to "Increase capability of women and girls to realize their rights, determine their life outcomes, and influence decision making in households, communities, and societies."

The U.S. Mission in Afghanistan's Gender Strategy identifies institutionalizing opportunities for the entry and advancement of educated women within the public, private, and civil society sectors as essential to preserving the progress Afghan women have achieved over the last decade as well as to establishing a platform on which to build on current advances as the country transitions. USAID's strategies aim to ensure that a "gender agenda" is not an issue on the fringes of national policy and programming but central to Afghanistan's social, political and economic advancement.

### **III. PURPOSE**

The purpose of this gender assessment for the socio-cultural determinates of nutrition is to produce a set of recommendations that will be used to develop future USG programs to address malnutrition in Afghanistan from a gender perspective and incorporated in the Nutrition Project Appraisal Document (PAD). The findings and recommendation of this assessment will be used to complement the gender analysis that will be prepared for the Nutrition PAD in accordance with USAID's Project Design Guidance and ADS 201.3.15.3. USAID will also use the results of this assessment to determine resource allocations and recommendations to the MoPH and other related ministries, other donors and stakeholders regarding nutrition programming in Afghanistan. This assessment will ensure that USAID interventions address the specific nutritional needs of women and children, without creating unintended, sustained, negative, or harmful effects on women, children, infants or men.

The findings and recommendations of this assessment will ensure that Afghan women and their families have equitable opportunities to participate in, contribute to and benefit from USAID's nutrition promotion activities. Gender analyses such as this one are intended to assist USAID Technical Offices to mainstream gender in their existing and upcoming projects.

The intended audience for this assessment is USAID decision-makers within the Mission Nutrition Working Group as well as the Gender Unit. The findings of this assessment will be shared with USAID/Washington staff, other development partners, GIROA officials and NGOs.

### **IV. Assessment Approach**

The assessment team will propose a methodology that includes both qualitative and quantitative data collection and analysis approaches. The methodology will be presented as part of the draft work plan and will include a proposed interview guide, a list of anticipated in-depth interviewees focus group subjects and community/household observations and

interviews, a draft site visit plan and a final timeline. Use of USAID’s Nutrition Strategy, concept paper or other related documents will be provided to better develop the Statement of Work (SOW) for the gender analysis if needed. The revised SOW, methodology and work plan will be submitted to the USADI/Afghanistan Gender Unit, Ms. Nicole Malick ([nmalick@state.gov](mailto:nmalick@state.gov)) and Ms. Alia El Mohandes ([AEIMohandes@state.gov](mailto:AEIMohandes@state.gov)), who will review and approve within five work days.

The assessment methodology should comply with ADS 205, be included in the work plan, and be attached to the final assessment report. Methodology strengths and weaknesses should be identified as well as measures taken to address any weaknesses. Any limitations in carrying out the planned methodology should be explained in the assessment report. All data collected and presented in the assessment report must be disaggregated by region, sex, socioeconomic status and Policy/Decision-making capacity whenever possible. The team must provide USAID with the opportunity to review assessment tools prior to piloting and final implementation.

The assessment should be participatory in design and implementation. USAID suggests that the Central Statistics Office be an active partner in this assessment process which should include, but is not limited to, the following:

- **Desk review:** GIRoA, other donor and USAID strategies, GIRoA, donor and USAID program documents, training materials, statistical analyses, and academic publications should be reviewed prior to the Team Leader’s arrival in Afghanistan. Information from these reports will be synthesized and analyzed for possible inclusion in the assessment methodology and/or assessment report.
- **Key informant interviews/focus group discussions:** Key individuals and groups will be interviewed to collect qualitative information related to the assessment questions. Interviews will employ semi-structured questionnaires and/or surveys. Interviews will be conducted with USAID/Afghanistan staff, relevant MoPH staff (including the Gender Department and select Provincial Health Officers), Ministry of Women’s Affairs (MOWA) and select provincial-level Departments of Women’s Affairs (DOWAs) staff, other donors, non-governmental organizations (NGOs) and civil society organizations (CSOs), and potential beneficiaries and/or end users.
- **Site visits/direct observation:** The assessment team should consider visiting a sample of communities, health facilities and provincial-level government institutions (DOWAs and PHOs, in particular) and most specifically households. The assessment team will develop a sampling frame to select the areas to be visited. Regional differences should also be noted, to include the south.

**K**

The assessment team is required to meet with an appropriate sample of all stakeholders identified. In the work plan the assessment team will develop and present to USAID a clear proposed sampling approach; the approach will be finalized after the assessment team has the opportunity to gather detailed information and discuss issues with USAID.

Due to the constantly changing security situation in Afghanistan, close coordination with USAID/Afghanistan will be necessary to ensure the assessment team selects suitable methods, approaches and site visits given the security environment. If security precludes

application of certain planned assessment methodologies, the assessment team will inform USAID immediately.

## V. ASSESSMENT QUESTIONS

The assessment will respond to the following research questions for this Gender Assessment: Socio-Cultural Determinants for Nutrition in Afghanistan.

1. **What are the communities' and households' knowledge/ perceptions, attitudes or practices effecting nutritious feeding patterns?**
  - a. **Diet Diversity:** What are the nutritional gaps in the diets of people at different geographic and socio-economic levels and what causes those gaps?
  - b. **Power dynamics:** What are the dynamics within the households or the communities which prevent or enable family members to have access to adequate nutritious food, potable water and health services?
  - c. **Cultural traditions:** What are the cultural traditions that limit the diversity of women's diets during pregnancy/ breastfeeding and practices of feeding young children feeding?

## VI. TEAM COMPOSITION

The assessment shall be conducted by a three-person specialist team consisting of one expatriate consultant and two Afghan topic specialists in addition to six local two-member data collection/observer teams: one male and one female, for focal group discussions and community/household observations and interviews. Female specialists are preferred whenever possible. The expatriate consultant should be a senior-level assessment specialist with extensive experience designing and conducting assessments and analyzing both quantitative and qualitative data skills. The expatriate should be assigned as Team Leader, and will be responsible for team coordination, assessment design, implementation and overall reporting. A statement of potential bias or conflict of interest (or lack thereof) is required of each team member.

*Minimum qualifications and experience for the **Expatriate Team Leader** are:*

- an advanced degree from an accredited university in the areas of public health, nutrition, gender or another relevant field;
- at least eight years' experience *conducting and analyzing* similar international, donor-funded programs;
- demonstrated relevant *technical* experience and a thorough understanding of nutrition with a gender lens and/or in conflict settings;
- demonstrated *gender* experience working with women's organizations and/or on gender issues in Afghanistan or the region in a similar context;
- at least six years of progressively responsible experience *managing staff* in a conflict affected environment;
- fluent oral and strong written English communications skills. Dari and/or Pashto skills highly desirable; and
- demonstrated interpersonal skills including diplomacy, tact, and the ability to negotiate and influence.

*Minimum qualifications and experience for Afghan Topic Specialist are:*

- a bachelor’s degree from an accredited university in public health, agriculture, or another relevant field;
- at least two years of relevant *technical* experience;
- at least two years of experience *conducting and analyzing* similar programs preferred;
- fluent oral and written Dari and/or Pasto skills; and excellent English communications skills; and,
- demonstrated interpersonal skills including diplomacy, tact, and the ability to negotiate and influence.

*Minimum qualifications and experience for Afghan Data Collector Team member are:*

(Each Team will be composed of one Afghan female and one male, in total 8 data collectors)

- a High School degree from an accredited High School;
- at least one years of relevant *technical* experience, especially in data collection;
- some experience *conducting and analyzing* assessments/evaluations preferred;
- fluent oral and written Dari and/or Pasto skills; and good English communications skills; and,
- demonstrated interpersonal skills including interpersonal communications, tact, and the strong observation, probing and listening skills.

## VII. ASSESSMENT SCHEDULE

The estimated time period for undertaking this assessment is a total of 55 working days for the Expatriate Team Leader, from o/a August 14, 2014 to November 15, 2014 with a six day working week in-country. It is expected the Team Leader will be in country by August 4 to start the assessment activities with the rest of the Team. The assessment timeline will be finalized between USAID and the implementing partner conducting the evaluation prior to initiation of the assessment.

The assessment team is required to work six days a week. Detailed level of effort (LOE) information is provided here:

Activity	LOE			Afghan Data/ Observer collector Team (4 x2 teams)
	Expatriate Team Leader	Afghan Specialist #1	Afghan Specialist #2	
Document review; develop initial work plan and methodology; draft questionnaire ; draft interview guide, list of interviewees (National/district), communities/households and site visit plan	2	3	3	
Travel to/from Afghanistan	4			
In-country preparation on work plan: methodology, questionnaires and site-visit plan logistics	5	2	2	
In-briefing with USAID, work plan (prior to meeting)	1	1	1	
Finalize work plan, methodology, interview guide and questionnaire, list of interviewees and	2	2	2	

site visit plan				
Training of Data/Observer Collector Teams on questionnaire and guidelines	2	2	2	2 x 8
Interviews/focus groups/household data collected with observations	21	21	21	32 x 8
Initial results from first phase of data collected analyzed and translation of collected data as needed	8	2	2	4 x 8
Mid-term briefing with USAID	.5	.5	.5	
Adjustments to questionnaires for second round of in-depth interviews, focal groups to verify results from first round of interviews	1	1	1	
Interviews/focus groups discussions verification	6	6	6	
Conduct data analysis and translation, draft preliminary report, one-pager briefer and prepare final presentation	10.5	5.5	5.5	
Final exit presentation to USAID (providing PowerPoint presentation, draft assessment report and one-page briefer)	1	1	1	
Final assessment report preparation	4	2	2	
<b>Total person days work</b>	<b>68</b>	<b>49</b>	<b>49</b>	<b>304</b>

## VIII. REPORTING REQUIREMENTS AND DELIVERABLES

1. **Initial Briefing:** Within two days of the Team Leader’s arrival in Afghanistan, the assessment team will have an in-brief meeting with USAID/Afghanistan’s OSSD Health Team and Gender Unit for introductions, presentation of the team’s understanding of the assignment, and discussion of the team’s initial assumptions, proposed methodology, key stakeholders, interview guide, site visits plan, and assessment timeline.
2. **Final Work Plan and Methodology:** Within three days of the Team Leader’s arrival in Afghanistan, the assessment team will provide USAID a final work plan for approval, to include:
  - a. proposed assessment methodology;
  - b. list of planned interview and focus group subjects;
  - c. interview guide;
  - d. site visit plan;
  - e. updated timeline, to include mid-term and exit briefings to USAID and provision of final assessment report and one-page briefer; and,
  - f. list of team members, roles, and contact information.
3. **Mid-term Briefing:** Mid-way through data collection and site visits, the assessment team will hold a mid-term brief with USAID to review the progress of the assessment with particular emphasis on addressing the assessment questions and a brief update on potential challenges and emerging opportunities and any amendments to questionnaire as needed.
4. **Out-Briefing:** Upon completion of the draft assessment report and before the Team Leader departs Afghanistan, the assessment team will conduct an out-briefing with USAID. The brief will provide a summary of the team’s key findings, conclusions and

preliminary recommendations. If a PowerPoint presentation is utilized, a copy of the electronic PowerPoint file will be provided to USAID prior to the briefing.

5. **Draft Assessment Report:** A draft assessment report will be delivered during the out-briefing for USAID comments. The report should discuss the assessment methodology, cite sources of information, discuss assessment findings and provide recommendations for future programming.

*Assessment Report Guidelines*

- The assessment report should represent a thoughtful, well-researched and well-organized effort to objectively assess the impact of gender socio-cultural norms on nutrition in Afghanistan.
- The assessment report must address all assessment areas and questions included in this statement of work.
- Assessment methodology shall be explained in detail, including any strengths or weaknesses in the methodology, or problems encountered while implementing the methodology.
- Sources of information, including any peer-reviewed or grey literature, will be properly cited and listed as an annex.
- All data presented in the assessment report will be disaggregated by gender, age group, and geographic area whenever feasible.
- Limitations to the assessment shall be disclosed in the report, with particular attention to limitations associated with the assessment methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Assessment findings should be presented as analyzed facts, backed by evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions.
- Conclusions should be specific, concise and supported by strong qualitative or quantitative evidence.
- Recommendations will be supported by a specific set of findings. They will also be action-oriented, practical, and specific, with defined responsible parties for each action.

*Assessment Report Format:*

The assessment report shall not exceed 50 pages, exclusive of the Title page, Table of Contents, List of Acronyms, Acknowledgments or Preface and Annexes and shall be written in English using Times New Roman 12 point font, 1.15 line spacing, consistent with USAID branding policy.

The assessment report shall include the following:

1. Title Page
2. Table of Contents (including Table of Figures and Table of Charts, if needed)
3. List of Acronyms
4. Acknowledgements or Preface (optional)
5. Executive Summary
6. Introductory Chapter
  - a. Brief statement on the purpose of the assessment, including a list of the main assessment questions
  - b. Brief statement on the methodology used in the assessment

- c. Explanation of any limitations of the assessment and how these limitations affect the findings
  - 7. Findings
  - 8. Conclusions
  - 9. Recommendations
  - 10. Annexes—annexes should be submitted as separate documents with appropriate file names (e.g., Annex 1—Assessment SOW) and headers within the document itself.
    - a. Assessment SOW
    - b. Assessment work plan, including the assessment design and methodology
    - c. List of site visits conducted as well as organizations and people interviewed including contact details
    - d. Copies of all tools developed and used, including survey instruments, questionnaires, discussion guides, checklists
    - e. Bibliography of key background documents
    - f. Meeting notes for all stakeholder meetings
    - g. Evaluation team roles, contact information and CVs
- 6. Final Assessment Report (English and Dari)<sup>9</sup>:** A final assessment report that responds to USAID comments and input shall be provided within five (5) days of receipt of USAID comments on draft report. The final assessment report shall follow the format and guidelines described above.

## **IX. USAID MANAGEMENT**

The assessment team will officially report to SUPPORT II, managed by Checchi and Company consulting, Inc. SUPPORT II is responsible for all direct coordination with the USAID/Afghanistan OPPD Monitoring and Evaluation (M&E) Unit through the Contract Officer's Representative for SUPPORT II. From a technical oversight perspective, the assessment team will work closely with members of USAID's Nutrition Working Group, Health Team and Gender Unit. All modifications to this statement of work, whether technical requirements, assessment questions, assessment team compositions, or timeline, must be agreed to in writing by the OPPD M&E Unit. In order to maintain objectivity, all final decisions about the assessment will be made and communicated to the contractor by OPPD's M&E Unit.

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<sup>9</sup> Dari Translation of the Final Assessment Report can be delivered up to 30 days after submission and approval of the English version.

## Annex I:

The assessment will consider the following questions to the extent possible as priority of the Gender Unit:

1. **Dietary Diversity**— what are the nutritional gaps in the diets of people at different geographic and socio-economic levels and what causes those gaps?
  - a. What are the common/traditional foods in the household in different seasons?
  - b. Is there a difference between foods in the household today from when they were growing up (during their grandparents' time)?
  - c. Was/Is there foods that are preserved in the household? Processed and stored annually? Seasonally? For continuous availability in the household? What foods? Who does this preservation process? Who decides on this and what will be preserved?
  - d. Which of these foods are eaten by which members of the household? And during what circumstances, i.e. during pregnancy? After delivery? During illness? Recuperation? Other social events or festivities?
  - e. What are the seasonal differences regarding food availability? Utilizations?
  - f. Do respondents grow their own food or buy it? How many growing seasons?

**Breastfeeding/Weaning:** Is there a difference to any of these practices with the sex of the infant/child?

- g. Do they know what colostrum is? When do they put the new-born to the mother's breast?
- h. Do they make special cheese or use animal colostrum? If so, why and how? Who eats this?
- i. Do they give the new-born anything besides mother's breast milk? Why? What? How often? When? How is it prepared?
- j. When do they introduce anything into the infant/child's mouth? What do they first introduce? Why? How often?
- k. How do they define weaning? (Introducing foods/liquids besides breast milk?) When do they start weaning? What foods/liquids do they use? When?
- l. Are there traditional foods for weaning? What? How do they access it? Make it? Store it? Reconstitute it?

**WASH:**

- m. Where do they get their daily water supply for drinking/cooking/washing?
- n. Who collects their water? In what? How is it stored? Is it boiled before use? How long is it boiled? Is any other method to purify the water used? What? Where do they get this product?
- o. Do they use soap? Do they buy it or make it? Where do they keep soap? (Near food processing and cooking areas? Near latrines? Or where they have open defecation? After they change/clean an infant or child defecating?)
- p. How do they clean or maintain a latrine or the area they have open defecation?
- q. Is there a clean source of water and piece of soap near the cooking area? The latrine? Or open defecation area? Is water and soap used after defecation?
- r. How often do different members of the family bathe? Is there a sequence to the bathing process? Is the bathing water used for other household chores? Does gender affect any of these practices?

- s. Do ill family members bathe? Children? When?
  - t. Where does the household dispose of grey water? Or does it get reused? When? Why?
2. **Power Dynamics**—what are the dynamics within the households or the communities which prevent or enable women and children and other family members have access to adequate nutritious food, potable water and health services?
- a. How many income earners are in the household?
  - b. Who are the decision makers in the households, and how does that change for various socio-health issues? Food procurement? Cooking? Processing? Storage? Medical treatment? Agricultural seeds and crops to grow? Who is educated for how long? Etc.
  - c. Who decides when and where to go for health care or advice when a woman or child is sick? Is preventive care sought and, if so, for what reasons and which members of the family? For what reasons is care sometimes delayed or foregone? Does the sex or age of the child/individual make a difference?
  - d. How are decisions made within the household with respect to antenatal care, childbirth assistance and infant child illnesses?
  - e. Who makes decisions regarding food acquisition, use, and intra-household allocation: who eats what, how much when?
  - f. What is the role of extended family (such as grandparents) in relation to women's and children's nutrition and decisions that affect their quality of life? (Access to education? Medical care? Treatment? Other life decisions?)
3. **Cultural Beliefs and Traditions**—what are the cultural traditions that limit the diversity of women's diets during pregnancy/ breastfeeding and practices of feeding young children feeding?
- a. What foods are taboo, for whom and when?
  - b. Until what age are children breastfed? Does that differ for boys and girls? How?
  - c. At what age are other foods introduced for children? What is acceptable for young children to consume/not consume and what gender considerations might impact that? (Please see above breastfeeding and weaning practices questions).
  - d. Does a pregnant woman work in the agricultural fields while pregnant? Or does she have weight bearing chores? If so how long in her pregnancy does she do this?
  - e. When or how often should a mother have children? Or what is the optimal space between pregnancies to have healthy children?
  - f. What does early marriage or adolescent marriage and child bearing have on the health and survival of the young infant and mother?
  - g. When does a new mother start to do chores after delivery? Work outside the house in other household chores? If so, please define these chores.
  - h. Does a mother with many children do agricultural chores or other household chores? If so, what chores does she do and who takes care of the young children and new born while she is doing these chores?
  - i. Is young mothers are still going to school or is working who takes care of the young children?

4. **Community Dynamics**—what are the enabling dynamics that already exist within communities that our programs could strengthen?
  - a. Are there support groups or networks available to women within the community, either informal or formal? What are these groups? And how could they support women in the community?
  - b. What factors within the family or community support women's agency (intrinsic relevance for women's individual wellbeing and quality of life; instrumental relevance for actions that improve the well-being of women and their families, and is required if women are to play an active role in shaping institutions, social norms, and the well-being of their communities) and empowerment?
  - c. How can health and nutrition services be strengthened taking into account gender dynamics?
  - d. How do various family members (men, women, and young/old) get information about pregnancy care, child care, nutrition, etc.? Have there been changes in the way/s they get information?
  
5. **Other barriers or opportunities**--What is community and households' knowledge/ perceptions, attitudes or practices on other barriers or opportunities to support nutritious feeding patterns exist at the family or community level?
  - a. What childcare practices other than feeding impact the overall level of nutrition for a young child?

## Annex II-Other Specific Nutritional Contributing Factors to under-nutrition in Afghanistan

### **Immediate Causes**

***Inadequate dietary intake:*** On average, Afghans consume only 132 grams of fruit and vegetables daily, far below the recommended minimum requirement of 400 grams daily according to the World Health Organization. Micronutrient deficiency is rampant in Afghanistan. Vitamins and mineral fortification during the processing for flours, oils, and other staple foods remains a rarity in Afghanistan, and processed foods imported from neighboring countries, which make up a significant portion of staple foods consumed in Afghanistan, are not required to be fortified.

***Disease:*** Repeated bouts of illness and infections affect nutritional status by decreasing dietary absorption, increasing blood loss and destruction of cells. Malnutrition compromises the immune system. Persistent illness is likely to be one of the major causes of chronic malnutrition and micronutrient deficiencies among children and pregnant mothers.

### **Underlying Causes**

***Inadequate access to and availability of food:*** Systematic weaknesses and failures with how food is produced, transported, stored, processed, and sold contribute to lack of availability and variety of nutritious food for large population segments in Afghanistan.

***Inadequate care for mothers and children:*** Inadequate infant and young child feeding practices are a major contributing cause to malnutrition in children. Only half of all children under six months old are exclusively breastfed, and about 70 percent of children under two years old received breast milk in addition to complementary foods. In addition to limited understanding of optimal feeding practices, the mother's own malnourished state that can lead to a state of depression and limited child/mother interactions can also affect feeding practices. Gender inequity and decision making in the household can contribute to malnutrition through inequitable and inadequate timely access to health services, other resources, and economic opportunities.

***Insufficient health services and unhealthy environment:*** Insufficient and timely access to health services is a major challenge for Afghanistan as more than 60 percent of the rural population lives more than one-hour travel time from any health facility. In 2010, USAID's health interventions for the Basic Package of Health Services (BPHS) was revised to include nutrition specific interventions for all Afghans; however implementation of such services remains weak.

Research shows that ***Water, Sanitation and Hygiene (WASH)*** interventions are also critical in preventing diarrhea and other infectious diseases that contribute to child under nutrition. Afghanistan has some of the lowest levels of access to water and sanitation in the world. In rural areas, only 27 percent of the Afghans have access to an improved drinking source. Only one-quarter of Afghans have access to improved latrines. Lack of functioning sewage systems, unhygienic practices for waste disposal, and unhygienic practices in both communities and the household threaten Afghanistan's water sources and contribute to the high rate of recurring bouts of gastrointestinal illnesses and diarrhea, especially among children under the age of two.

**ANNEX II: WORKPLAN**

**DRAFT WORKPLAN**

**GENDER AND NUTRITION ASSESSMENT**

**OF**

**IMPROVING NUTRITION OUTCOMES  
FOR TARGET POPULATIONS PROJECT**

Submitted on:

**August 27, 2014**

**Evaluation Team:**

**Anne T. Sweetser, Ph.D., Team Leader  
Dr. Humayoun Ludin, Nutrition Specialist  
Manizha Wafeq, Gender M&E Project Manager  
Mussarat Arif, Gender M&E Specialist  
Kamal Burhan, Document Manager**

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## **1. PURPOSE OF THE GENDER AND NUTRITION ASSESSMENT**

The Improving Nutrition Outcomes for Target Populations project aims to “scale up effective, integrated interventions that will improve nutrition to save lives, build resilience, increase economic productivity, and advance development in Afghanistan.” It will focus on the first 1,000 days of a child’s life, starting with women’s health prior to and during pregnancy and continuing through neonatal feeding, exclusive breast feeding for six months, and complementary feeding of infants from six months to two years. It will include initiatives in public health, including nutrition, health services, agriculture, and water supply, sanitation, and hygiene (WASH). The purpose of the gender and nutrition assessment is to enhance understanding of the roles and responsibilities of men and women with respect to various socio-cultural dimensions affecting nutrition and care of women and children throughout the country. It will develop evidence-based recommendations for incorporating gender dimensions in the project to improve maternal and infant nutrition, increase demand for and access to high-quality nutrition and health services, boost production of a wide variety of foods, and promote changes in hygiene and sanitation.

Many factors together influence infant feeding practices, including knowledge, attitudes, traditions, societal norms, and support from family members and the wider community. In Afghanistan, strong traditions and related social pressures reinforce often rigid ideas and practices pertaining to gender roles. Power and authority are held by men who prioritize family honor over women’s control of resources and decision making, and limit their mobility, including access to information, health care, and education. While social roles are slowly evolving in larger urban areas, social change is a generational process and new ideas are often perceived as threats to men’s identity and to social cohesion in rural areas. Special efforts are therefore required to find ways that make men perceive innovations as leading to the intended results – smarter, healthier children – and as in their best interest and not disruptive of the moral order.

This assessment will therefore focus at the household and community level, and probe the gender-related attitudes and mores that influence existing practices in child feeding, decision making about seeking health care for women, food production and consumption, and constraints related to water supply, hygiene, and sanitation. By speaking with male and female community health workers, midwives, and basic health center staff, it will gain further insight into gender-related dimensions of health-seeking behavior and elicit suggestions about how to improve service provision and expand outreach. Conversations with agricultural extension workers, school teachers, and other community leaders will provide insight into the efficacy and entailed challenges of efforts to promote change.

## **2. METHODOLOGY**

The Gender and Nutrition Assessment will be guided by USAID’s Gender Equality and Female Empowerment Policy of March 2012, in which both men’s and women’s views and interests are taken into account. A team consisting of eight interviewers, half men and half women, joined by a Team Leader (Expat), a National Nutrition Consultant, and SUPPORT II’s three Gender M&E Specialists, will carry out interviews in five regions: Kabul, Kandahar, Nangarhar, Badakhshan, and Herat. In each region, two villages, one with a basic health center, plus the provincial city, will be studied. Interviews will be conducted with men and women in each village and in the city for two days each. Interviewers will ensure

inclusion of a representative sample of poor, medium, and relatively-comfortable families, including at least one female-headed household in each community. In the provincial capitals, in addition to household interviews, small group discussions with male and female university students will amplify understanding of change in recent decades. The interviewers will also observe an urban clinic or hospital and interview staff members and some patients.

Interviewers will be required to review all data collected and notes made each day for completeness and accuracy and to translate to the extent possible notes written in Dari or Pashto into English. Some data will be immediately entered into Excel tables, and this will continue in the office after completion of the interviewing. Comments will be fully translated and typed to permit analysis using the qualitative data analysis tool atlas.ti. No personally identifying information will be included in the analysis; rather, rural and urban areas of each province will be indexed. After completing each interview, staff will take photographs of the families interviewed, as permitted, using GPS cameras to verify their conduct of the work.

The Team Leader or senior members of the team (depending upon the ability of the Team Leader to travel outside Kabul due to security concerns) will interview staff of key Government Ministries and Provincial Departments, donors, and international and local NGOs involved in implementation of relevant programs in all locations.

The following qualitative data will be analyzed:

	<b>Method</b>	<b>Data</b>	<b>Sources</b>
a.	Document Review	<ul style="list-style-type: none"> <li>▪ USAID Nutrition Concept Paper</li> <li>▪ Relevant USAID policies (gender, nutrition, etc.)</li> </ul>	USAID, Checchi Inc.
b.	Literature Review	<ul style="list-style-type: none"> <li>▪ National and Regional Nutrition Assessments by GIRoA, UNICEF, and others</li> <li>▪ Feed the Future documents</li> <li>▪ Studies on Gender in Afghanistan</li> <li>▪ Documents presented during interviews with government Ministries, provincial departments and implementing agencies</li> <li>▪ USAID’s Infant and Young Child Nutrition Project</li> <li>▪ Alive and Thrive project (Bill and Melinda Gates Foundation)</li> </ul>	Government, donors, journals
c.	Interviews and Focus Groups	<ul style="list-style-type: none"> <li>▪ Interviews with Government Ministries, Provincial Departments, donors, project implementers including</li> </ul>	Team Leader and senior Afghan and Checchi SUPPORT II staff as needed

		<p>NGOs</p> <ul style="list-style-type: none"> <li>▪ Household, community leader, and health worker interviews in two villages of one district plus provincial capitals in Kabul, Nangarhar, Herat, Kandahar, and Badakhshan Provinces</li> </ul>	<p>Team of eight men and women, plus Senior Afghan nutritionist and Checchi SUPPORT II staff will be trained and conduct the interviews</p>
d.	Site visits	<ul style="list-style-type: none"> <li>▪ Observation notes on villages, households, and health centers</li> </ul>	<p>Team members</p>

The information derived from the above sources should provide the following information for analysis:

- Extensive background information on nutrition status throughout Afghanistan;
- Examples of relevant approaches successfully used in other societies;
- Achievements and challenges in on-going Government and donor programs;
- Current beliefs and behaviors related to nutrition, women's and children's health, child feeding, production and consumption of a wide variety of foods, and WASH;
- Cultural constraints affecting women's roles, men's and women's access to information about nutrition, gardening, disease prevention and treatment, WASH, and access to quality health care and nutrition counseling;
- Attitudes of men and women about the roles and responsibilities of men and women related to the health and access to proper nutrition and WASH for women and children;
- The perceived necessity of existing roles vs. the scope for change and the incentives and assurances required to facilitate change;
- Services delivered and challenges faced by primarily rural health workers.

### **TEAM MEMBERS**

Anne T. Sweetser, Anthropologist, Team Leader

Email: [asweetser5@gmail.com](mailto:asweetser5@gmail.com)

Tel: +1-702-572-0724 (USA); +93(0) 729 001 683 (Kabul)

Dr. Homayoun Ludin, National Nutrition Consultant

Public Nutrition Department, Ministry of Public Health

Email: [homayounludin@gmail.com](mailto:homayounludin@gmail.com)

Tel: +93(0) 729 001 684

Checchi SUPPORT II staff:

Mussarat Arif, M&E Gender Specialist

Email: [marif@checchiconsulting.com](mailto:marif@checchiconsulting.com)

Tel: +93(0) 729 001 672

Kamal Burhan, Document Manager  
Email: [kburhan@chechiconsulting.com](mailto:kburhan@chechiconsulting.com)  
Tel: +93(0) 729 001 666

Manizha Wafeq, Gender M&E Projects Manager  
Email: [mwafeq@chechiconsulting.com](mailto:mwafeq@chechiconsulting.com)  
Tel: +93(0) 729 001 696

### 3. DELIVERABLES AND ACTIVITY SCHEDULE

<b>Deliverables</b>	<b>Date Due</b>
In-briefing / SOW Presentation	August 24
Draft Work Plan to USAID	August 26
Final/USAID-approved SOW/Work plan	Sept. 3
Mid Term Briefing	October 12
Draft of Report	November 3
Comments back from USAID	November 13
Final Revised Report	November 16

## Annex I: List of Key Interview Questions

Topics for interviews with householders, health practitioners, and program implementers

### **I. Village**

#### **A. Women**

Basic information and attitudes about:

1. Family composition
2. Both the respondent's experience and local ideals about age of marriage and first pregnancy, and about the number and spacing of children
3. Roles of men and women within the family
4. 24-hour food preparation history; consumption by men, women, and children; and storage of any leftovers
5. Time usage patterns including radio and TV
6. Good and bad foods during pregnancy and lactation; for neo-nates, infants to six months, from six months to one year, and from one to two years of age; and why
7. Antenatal care, location of delivery of youngest/last child (live or dead)
8. Health history and details of health seeking behavior for most recent disease episode of youngest child (including alternative practitioners)
9. Water source, procurement, usage, storage, and disposal after use
10. Hygiene practices and sanitation
11. Interest in and possibility of various types of group activities for women within the village
12. What information desired by the interviewee
13. What changes in community desired by the interviewee

Checklist: brief description of house, garden, cooking practices (if observed), water storage, latrine, hygiene, and waste disposal, both solid and grey water

#### **B. Men**

Basic information and attitudes about:

1. Family composition, number of people supported
2. Food production including vegetable gardens, amount sold, amount eaten by family
3. Food consumption patterns
4. Water supply, procurement, and storage, plus hygiene and sanitation
5. Education and sources of information including radio, TV, and newspapers
6. Health history plus access to and quality of health services (including alternative healers) and nutritional information and counseling received
7. Men's and women's roles including ideal age of marriage, number of children, roles of men and women within the family and community
8. Reasons for the perceived necessity of these roles and responsibilities, plus degrees and areas of flexibility given particular conditions and incentives

9. Attitudes about “women’s empowerment,” and the possibility of learning group within the village
10. Information and social change desired

## **II. Community Health Workers, Midwives, and BHC/CHC/DH staff**

1. Decision to join, qualifications required, and length of service
  2. Typical activities – query: growth monitoring, vaccinations, antenatal care, deliveries, injury and disease treatments, household visits, record keeping
  3. Training received – quality and applicability, and additional desired
  4. Knowledge of nutrition and frequency of counseling, including examples of recommendations for common ailments, and counseling sessions if they occur
  5. Greatest success and hardest case ever including referral, if any, and outcome
  6. Water supply, storage, hygiene practices, sanitation
  7. Adequacy and procurement of supplies, support, supervision, reporting requirements
  8. Men’s and women’s attitudes toward their work, overall satisfaction
  9. Constraints of women’s access – for selves, babies and children, violence
  10. Cultural and institutional changes needed to improve practice
- Checklist: supplies, hygiene practices, for BHC/CHC/DH: nutrition posters publicized?

## **III. Government, Donor, and NGO staff**

With emphasis on community outreach:

1. Purpose and activities of existing and planned programs
2. Geographical distribution
3. History of implementation
4. Staffing, filled positions, turnover
5. Training component
6. Supervision and reporting
7. Procuring, supplying, funding and cost management
8. Monitoring and evaluation, ability to verify data collected, and use for future planning and responding to identified needs
9. Success and challenges
10. Process for adjusting activities and intended changes

Annex II: Proposed Schedule - Rev per New UNHAS Flight Schedule

Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
23	24 <b>IN-BRIEF</b>	25	26	27 <b>WORK PLAN TO USAID</b>	28 questions and check lists	29
30 questions and check lists / translation	31 questions and check lists / translation	<b>SEPT 1</b> questions and check lists / production	2 questions and check lists / production	3 team training: intros/team/research expectations	4 team training: types of questions/ role plays	5
6 training: review of interview questions	7 training: note taking and transfer of some data to excel	8 prepare for field practice in Kabul	9 HOLIDAY (Masood)	10 first day of field practice (urban)	11 review, discussion, data handling	12
13 urban Kabul  ATS interviews	14 rural A Kabul  ATS interviews	15 rural A Kabul  ATS interviews	16 rural B Kabul  ATS interviews	17 rural B Kabul  ATS interviews	18 discussion and analysis	19
20 discussion and analysis	21 planning for first two provinces	22 teams travel to first two provinces - Badakhshan and Kandahar	23 first 2 provinces - interviews	24 first 2 provinces - interviews  ATS to Badakhshan	25 first 2 provinces - interviews  ATS prov interviews	26
27 first 2 provinces-interviews  ATS prov interviews	28 first 2 provinces-interviews  ATS prov interviews	29 teams and <b>ATS</b> return to Kabul	30 discussion and analysis	<b>OCT 1</b> discussion and analysis	2 TEAM OFF FOR PRE-EID TRAVEL	3 EID
4 EID  ATS learns Atlas.ti!  == >>	5 EID  ATS analyzes two provinces  == >>	6 EID	7 EID	8 EID some team members or staff plan next 2 provinces	9 EID some team members or staff plan next 2 provinces	10 EID
Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday

11	12 <b>MID TERM REPORT</b>	13 team prepares for next 2 provinces	14 teams and <b>ATS</b> travel to second 2 provinces - Nangarhar and Herat	15 interviews  <b>ATS prov interviews</b>	16 interviews  <b>ATS prov interviews</b>	17
18 interviews  <b>ATS prov interviews</b>	19 interviews  <b>ATS to Kabul</b>	20 interviews	21 teams return to Kabul	22 discussion and analysis	23 discussion and analysis	24
25 discussion and analysis  <b>ATS work with team and analysis and writing == &gt;&gt;</b>	26 discussion and analysis	27 discussion and analysis	28 discussion and analysis	29 discussion and analysis	30 <b>* final wrap up and evaluation</b>  <b>ATS analysis and writing == &gt;&gt;</b>	31
<b><u>NOV 1</u></b>	2	3 <b>DRAFT FINAL REPORT &amp; PRESENTATION</b>		5  <b>ATS DEPARTS</b>		

\*Teams will complete their work when all translation is finished and comments are typed in Word, other data is entered in Excel, experience and learning is discussed together, and the evaluation is conducted.

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#### ANNEX IV: SCHEDULE OF MEETINGS

<i>Date</i>	<i>Organization</i>	<i>Name</i>	<i>Title</i>	<i>Phone</i>	<i>Email</i>
9/15/2014	Organization of Afghan Midwives. Kabul	Mursal Musawi Hella Gharshin	Executive Director VP and Acting President	0794454100 0778080372 --	<a href="mailto:mmusawi@afghanmidwives.org">mmusawi@afghanmidwives.org</a> <a href="mailto:h.gharshin@afghanmidwives.org">h.gharshin@afghanmidwives.org</a>
9/16/2014	Save the Children, Kabul	Dr. Mohammad Akbar Sabawoon	Health & Nutrition Senior Advisor	0795998385 0700250542	<a href="mailto:mohammadakbar.sabawoon@savethechildren.org">mohammadakbar.sabawoon@savethechildren.org</a>
9/18/2014	Aga Khan Foundation, Afghanistan, Kabul	Nasrullah Orya Urmila Simkhaha	National Coordinator, Health Program National Gender Advisor	0794602979 0791981901	<a href="mailto:nasrullah.orya@akdn.org">nasrullah.orya@akdn.org</a> <a href="mailto:urmila.simkhada@akdn.org">urmila.simkhada@akdn.org</a>
9/21/2014	Ministry of Women's Affairs, Kabul	Marukh Yusufzai Maghalare Sahlir Kharah Hussain Ali Moieen	Director Health and Nutrition Specialist Expert on Policy and Economic/ HCA/PRCPW Working Team Member	-- -- 0799356464	-- -- <a href="mailto:women.econo-emp@hotmail.com">women.econo-emp@hotmail.com</a>
9/24/2014	CAF Badakhshan (responsible for BPHS district 1)	Dr. Memon Jalaly	Project Manager, Badakhshan	0777822394	<a href="mailto:pm.caf.bdk@gmail.com">pm.caf.bdk@gmail.com</a>
9/25/2014	Provincial Directorate of Agriculture and Livestock Badakhshan	Dr. Alim Alimi	Director	0799272961	--
9/25/2014	AKDN, Badakhshan (responsible for BPHS District 2 and EPHS)	Dr. Fahim Afridi Sayad Mir Shirzada	Regional Program Manager Nutrition Advisor	0792596388	<a href="mailto:Fahim.afridi@akdn.org">Fahim.afridi@akdn.org</a> <a href="mailto:mir.shirzad@akdn.org">mir.shirzad@akdn.org</a>

9/28/2014	Department of Women's Affairs, Badakhshan	Pohanmal Zufnoon Hassam Natiq	Director of Women's Affairs	0776787007 / 0799812258 / 0756310020	<a href="mailto:Z-atiq@yahoo.com">Z-atiq@yahoo.com</a>
9/28/2014	Save the Children, Badakhshan	Abdul Qadir Baqakhail  Dr. Kabir Karimi	Provincial Senior Manager, Badakhshan and Takhar Provinces  Nutrition Officer	0729904504  --	<a href="mailto:Qadir.Baqakhail@savethechildren.org">Qadir.Baqakhail@savethechildren.org</a>  <a href="mailto:Kabir.Karimi@savethechildren.org">Kabir.Karimi@savethechildren.org</a>
9/28/2014	FAO, Badakhshan	Nazifa Natiq	Nutrition Program Officer	0799431937	<a href="mailto:nazifa.natiq@fao.org">nazifa.natiq@fao.org</a>
9/28/2014	Ministry of Health Badakhshan Province	Dr. Abdul Hadi Shahidi	Nutrition Officer	0786069663 / 0795808556	<a href="mailto:shahidi.bdk@gmail.com">shahidi.bdk@gmail.com</a>
10/8/2014	World Health Organization, Kabul	Dr Sharifullah Haqmat  Dr. Mohammad Qasem Shams  Sini Ramo	NPO, Gender, Human Rights and Human Resource Development  Nutrition, National Professional Officer  Technical Officer, Gender and Communications	0799135714  0799373529  0782200354	<a href="mailto:haqmals@afg.emro.who.int">haqmals@afg.emro.who.int</a>  <a href="mailto:shamsm@afg.emro.who.int">shamsm@afg.emro.who.int</a>  <a href="mailto:ramos@afg.emro.who.int">ramos@afg.emro.who.int</a>
10/9/2014	Office of the Special Representative of the European Union in Afghanistan  Delegation of the European Union in Afghanistan	Michael Pedersen  Fazal Mohammad Zameer	Human Rights and Rule of Law Advisor  Project Officer, Health Section	0790489941  0700200708	<a href="mailto:Michael.PEDERSEN@ext.eeas.europa.eu">Michael.PEDERSEN@ext.eeas.europa.eu</a>  <a href="mailto:Fazal-Mohammad.Zameer@ec.europa.eu">Fazal-Mohammad.Zameer@ec.europa.eu</a>
10/14/2014	UNICEF (Kabul)	Dr. Zakia Mahroof	Nutrition Officer		<a href="mailto:zmahroof@unicef.org">zmahroof@unicef.org</a>

10/16/2014	BDN (Bakhtar Development Network)	Dr. Faraidon Sultani	HRT.PCH,Project Manager	0797359295	<a href="mailto:bdn.sultani@gmail.com">bdn.sultani@gmail.com</a>
10/16/2014	Agriculture, Irrigation, and Livestock Department of Herat	Eng. Hamidullah Naseri	General Manager Extension Department Agriculture	0797797603 0778145616	<a href="mailto:hamidullahnaseri@yahoo.com">hamidullahnaseri@yahoo.com</a>
		Ghulam Rabbani Azadmanish	Extension Advisor, Herat DAIL	0798423004	<a href="mailto:azadmanish1@gmail.com">azadmanish1@gmail.com</a>
		Nilofar Fashanuji	Home Economics extension officer	0798998222 0700429700	<a href="mailto:nilofarfashanji@gail.com">nilofarfashanji@gail.com</a>
		Abdul Basir Ahmad	Home Economy Manager	0798205502	<a href="mailto:basiramirahmadi@yahoo.com">basiramirahmadi@yahoo.com</a>
10/16/2014	NEI (Nutrition and Education International)	Mohammad Niaz Rahimi	Regional Program Director (Herat)	0794502686	<a href="mailto:niazmohammad.rahimi@neifoundation.org">niazmohammad.rahimi@neifoundation.org</a>
		Arif Ayobi	Training Center Coordinator	0781824977	<a href="mailto:arif.ayobi@neifoundation.org">arif.ayobi@neifoundation.org</a>
		Sebghatullah Naviri	Agronomist	0790308038	<a href="mailto:sebghatullah.naviri@neifoundation.org">sebghatullah.naviri@neifoundation.org</a>
10/16/2014	USAID	Nadia Sakhi	(Assisted with contacts in Herat)	0702636310	<a href="mailto:nadiasakhi@yahoo.com">nadiasakhi@yahoo.com</a> / <a href="mailto:NSakhi@state.gov">NSakhi@state.gov</a>
10/18/2014	Directorate of Women's Affairs (Herat Province)	Wahida Azizi	General Manager, Planning	0795751445	<a href="mailto:wahica.azizi84@yahoo.com">wahica.azizi84@yahoo.com</a>
10/18/2014	Directorate of Education	Khalili Ahmad Torna	Director of Planning and Reporting	0794786463	--
10/18/2014	NEI soy milk production facility	Niaz Mohammad Rahimi	Regional Program Director	0794502686	<a href="mailto:niazmohammad.rahimi@neifoundation.org">niazmohammad.rahimi@neifoundation.org</a>
10/19/2014	Directorate of Rural Reconstruction and Development (Herat)	Mahmood Shah Majedi	Social Development Manager	0700435441	<a href="mailto:mahmood_majedi@yahoo.com">mahmood_majedi@yahoo.com</a>

10/19/2014	AIL (Afghan Institute of Learning)	Walishah Bahrah Ehsan Ahmad Sahel	Senior Advisor General Academic Advisor	0700404320 0700578920 0794231068	<a href="mailto:walishash_Bahrah@yahoo.com">walishash_Bahrah@yahoo.com</a> <a href="mailto:ehsansahel.ail@gmail.com">ehsansahel.ail@gmail.com</a>
10/19/2014	UNICEF (Herat)	Mohammad Qasim Nazari	Project Officer WASH	0798507662	<a href="mailto:mqnazari@unicef.org">mqnazari@unicef.org</a>
10/21/2014	World Vision (Herat office)	Alice Songwa	Program Manager MUNCH (Maternal and Under Five Nutrition and Child Health)	0796590735	<a href="mailto:Alice_Songwa@wvi.org">Alice_Songwa@wvi.org</a>
10/23/2014	DFATD, Embassy of Canada	Ryan Legault McGill	First Secretary, Development	0701108864	<a href="mailto:Ryan.LegaultMcGill@international.gc.ca">Ryan.LegaultMcGill@international.gc.ca</a>
10/29/2014	Ministry of Public Health	Dr. Hamrah Khan	Gender Director	0799144415	<a href="mailto:drhamrahkhan@gmail.com">drhamrahkhan@gmail.com</a>
10/30/2014	DFATD, Embassy of Canada	Renata Pistone	First Secretary, Health	0701108808	<a href="mailto:Renata.Pistone@international.gc.ca">Renata.Pistone@international.gc.ca</a>

## **ANNEX V: DATA COLLECTION INSTRUMENTS**

Included are:

1. Clinic Observation Checklist
2. Clinic (Health Worker) Questions
3. Focus Group Themes
4. Household Interview Checklist
5. Men's question list
6. Men's recording form
7. National / Provincial Interview Questions
8. Women's Question list
9. Women's recording form
10. Village Project (STC) Questions

**Clinic Observation Checklist:**

Type of clinic: \_\_\_\_\_ Location:

\_\_\_\_\_

Date: \_\_\_\_\_ time of arrival and departure:

\_\_\_\_\_

Team members:

\_\_\_\_\_

Number and types of rooms:

\_\_\_\_\_

Posters about nutrition / HIV / other?

\_\_\_\_\_

Cleanliness:

\_\_\_\_\_

Arrangements for waste disposal?:

\_\_\_\_\_

Supplies and Equipment:

\_\_\_\_\_

Separate areas for men and women?

\_\_\_\_\_

Separate areas for TB patients or other infectious diseases?

\_\_\_\_\_

Number and types of staff present:

\_\_\_\_\_

Number called to come later (if any) (because you are there?) :

\_\_\_\_\_

Number of patients while you were there:

\_\_\_\_\_

Average waiting times:

\_\_\_\_\_

Problem(s) presented:

\_\_\_\_\_

Questions asked including history and prior treatment of the problem:

\_\_\_\_\_

\_\_\_\_\_



medicines prescribed:

---

Clarity of instructions / explanations:

---

Told to return for follow up? Yes no How much later?

---

Referral to higher health center given? Yes no To  
where?: \_\_\_\_\_

Specific food recommended?:

---

Your perception of the practitioner's attitude toward the  
patient: \_\_\_\_\_

Your view: quality of listening to patient:

---

#### FOLLOW UP OUTSIDE

Patient's attitude about the clinic:

---

about the health worker:

---

satisfied with this visit: yes no Why(not)?:

---

Did the patient understand prescription? Yes no Why(not)?

---

How much to take and when?

---

Why to eat or avoid certain foods?

---

QUESTIONS for CHW and BHC Workers:

How long have you worked here / done this job?

What types of work do you typically do?

If not mentioned: Do you monitor children's growth? (keep records?)  
Give vaccinations?  
Conduct antenatal exams?  
Advise women about breastfeeding?

Do you visits homes / villages? How often?

How many people do you see / treat each week (on average?)

What are the most common problems in this area?

What proportion of women are anemic? What do you recommend?

What proportion of mothers say they do not have enough milk? What do you recommend?

What proportion of infants are underweight and malnourished? What do you recommend?

How often do you make recommendations about foods to eat or to avoid?

Do people follow your advice?

If not, why do you think that is?

How often do you refer people to the [next higher level] for care?

Are you happy with this job?

What changes would you like to make your work more effective?

Do you feel that your training was sufficient for all the problems you see?

What additional or other types of information would you like to have?

Would you like to learn more about nutrition for mothers and babies to help people here better?

Do you have all the equipment and supplies you need?

Are you able to get more easily when you need them?

What do you have to do to get more supplies?

Re: men – do men bring children for consultation? How often?

Do men encourage women to contact you for help?

(or) Do they object to sending their wives to the BHC (out of the village?)

Do men sometimes beat their wives? Why?

Do they become angry if there is not enough food?

At what age to most girls get married?

At what age to most women have their first child?

Always last question: What did I leave out? What else would you like to tell me?

## Focus Groups -- Themes

1. Getting settled, Introductions, Setting the rules  
minutes 10
2. What are the most important changes in gender roles that are underway now?  
(Maybe go around the table and ask each person to mention one thing.)  
Work with the group to choose probably three to discuss (first): 20  
minutes Who is making these changes? (eg: urban only?)  
Who (if anyone) is opposing them and why? (eg: men only?)
3. How are these changes affecting 20 minutes  
each
  - a) the number of children that people your age want  
and how they would be spaced,
  - b) how pregnant and lactating women are cared for
  - c) how babies and infants are being fed and cared for?

## IV. THANK YOU!!! and Best Wishes....

\*\* Please review the notes on running focus groups and be sure to set up the room before people arrive.

## Household Interview Checklist

### Type of house

Floor

### Type of latrine / toilet

Clean?

(Location / Distance)

### Water supply

Containers for carrying (type)

Clean?

Storage container

Clean?

Covered?

Water quality (cloudy, dirty, smelly, odd color etc.)

### Hand washing

Soap there?

How near?

### Garden

Estimate size

General state

### Kitchen

Cleanliness

Type of stove / fuel

Storage of cooked food

## MEN's QUESTION LIST

### 1. FAMILY COMPOSITION

How many people live in this household? Old men, old women, married men, married women, unmarried boys and men, unmarried girls and women, baby/infant boys, baby/infant girls?

If there is more than one married couple – how many separate kitchens are there ?

How many people eat from each kitchen?

How many income earners are there?

What work do they do?

Do they make about the same amount of money?

If no, relative proportion?

How many people does each support?

### 2. HOME BASED PRODUCTION

#### In the summer:

What field crops do you grow? Eg: wheat, rice, maize, clover alfalfa etc. (for animals)

What percentage to you sell, use to pay debt, keep for eating, keep for seed

What is the total cash value of amount sold or used to pay debt?

What garden crops do you grow?

What percentage to you sell, use to pay debt, keep for eating, keep for seed

What is the total cash value of amount sold or used to pay debt?

What tree crops (fruits and nuts) do you grow?

What percentage to you sell, use to pay debt, keep for eating, keep for seed

What is the total cash value of amount sold or used to pay debt?

How many cows, oxen/bulls, camels, goats, sheep, chickens, others (what?) do you have?

What percentage to you sell, use to pay debt, keep for eating, keep to breed  
What is the total cash value of amount sold or used to pay debt?

What agricultural and tree crop, gardening, and livestock work do old men, old women, men, women, boys, girls do?

Would you show me your fields, garden, trees, animals (later?), please?

In the winter:

What do old men, old women, adult men, adult women, boys, girls do?

Who does these tasks: gathering wood, clearing snow from the roof, caring for livestock, getting water carding and spinning wool, making carpets. Other???

### 3. ROLES OF MEN AND WOMEN WITHIN THE FAMILY

Re: old men in the family, older women, adult men, adult women, boys, and girls

Who makes decisions about shopping, children going to school, food to eat, visiting the clinic, when and who children should marry, and what jobs people should do?

What are they responsible for?

How (if at all) are these roles changing?

What is causing these changes?

Who is responsible for disciplining young men who harass women?

Or is it only the woman's fault? Why?

What if she needs to take a child to the health center?

Can she go without your permission?

Don't you trust her to use good judgment?

Why can't men tell other men that the health of their children is more important than what they think about peoples' wives going to the clinic??

### 4. EDUCATION

How many of the boys / the girls go to school? Why(not)?

How many years should a boy / a girl go to school? Why?

Did you ever go to school? For how many years? Did you enjoy it?

Do you remember how to read and write?

Probe: What difference did this make in your life?

What is the most distant place you have visited? Why?

How many times have you gone to [the provincial capital city]? Why?

Do you have a mobile phone?

How many people in your family have a phone?

#### 5. AGE OF MARRIAGE, CHILD BEARING

How old were you when you got married?

What do people think is the best age for a woman to get married? Why?

Who decides when girl should get married?

What do people think is the best age for a man to get married? Why?

Who decides?

What do people think is the best age for a woman to get pregnant for the first time? Why?  
Why decides?

What do people think is the best number of boys? of girls? Why?

How much time is good between babies? Why? Who decide?

#### 6. ANTENATAL CARE AND DELIVERY OF LAST CHILD (dead or alive)

When you wife was last pregnant, how many times did she visit the CHW? midwife?  
BHC? etc

What advice was she given? Was she told why? If so, for what problem(s)?

Was she told anything about good and bad foods? Why (for each problem?)

Was she told to take or avoid any medicines? Why?

Where did she deliver her last baby?

Who decided she should do it that way?

Who helped?

If men knew more about pregnancy would they be able to provide more help to their wives?  
(Isn't this their duty in Islam?)

Is it (not) important for men to know about pregnancy and child birth? Why(not)?

Should(n't) they know what foods and medicine their pregnant wife needs? Why(not)?

Would you like to know more about pregnancy and child birth?

About what foods and medicines a pregnant and breast feeding mother should eat?

## 7. YOUR TIME USE

What do you typically do every day – these days / at this time of the year?

What things do you do first every morning? later morning?, early afternoon?, later afternoon?, evening?

What things do you do one or more days a week? How many days a week each? Prompts:  
Collect fire wood, buy things in the bazaar, make decisions about community life, debate  
about national politics, others....

How much time do you spend with your children most days?

Do you listen to the radio? Watch TV? For how long each time?

Usually how many days a week? When: morning / afternoon etc.?

Do you have a favorite program or two? Why is that / each your favorite?

## 8. WASH

*Water*

Where does your family get water? (river, pond, well, pump, standpipe, in-house faucet)

Who carries it? Who helps? (boys? girls?) Why(not)? Is this fair? PROBE! How far is it carried?

How many times a day is it collected?

What containers are used?

Is it delivered? Who delivers it? How many times a day? Do you have to order it each time? How do they deliver it? (carry, cart, donkey?)

How much do they bring each time?

How much does it cost - per amount delivered?

Is the water clean?

If not, what is wrong with it? -- dirty, cloudy, smelly, funny tasting etc.?

Is it treated at home? How?

Where is the water stored?

What is done with used water? (throw it?, drain?, put on garden?, other?)

What is done with food scraps? Waste paper? Plastic (bags and bottles etc.)?

### *Sanitation*

Do you have a latrine? a toilet? flush type? What other do you use?

Is it in the house? Or how far away is it?

If it is outside, can a woman go at any time during the day?

Does a woman avoid drinking water so she doesn't have to go too often?

What if she is sick? Especially if she has diarrhea? What can she do?

Is it safe at night for a woman to go at night? For a man? What causes the danger? People? Spirits?

What should be done protect women, especially those who are sick?

Isn't this the men's responsibility? PROBE!

What should be done if men harass the women? Probe!

## *Hygiene*

Where do you wash your hands?

So you always use soap?

How often do you wash your hands?

At what times do you wash your hands (after toilet, before eating etc.)

## 9. FOOD

How many times does your wife cook every day? Make bread? Make tea?

What did you eat at home last night? This morning? ==> get 24 hours of home food consumption patterns: Does everybody eat at the same time? Or men first? Draw a circle or show a circle on paper – how much did the men eat of meals in the last 24 hours?

How was the rest divided among the rest of the people? How much did the women eat? the boys? the girls?

Draw another circle: When you have meat, how much do the men eat? the women? the boys? the girls?

Why do men eat first?

Why is food divided this way within the family?

At what age do the boys start to eat with the men? Who decides?

Are the women and children sometimes hungry? Why(not) ?

Do you know if they are hungry?

What do you do if there is not enough food?

Do men sometimes beat their wives if there isn't enough food? For what other reasons?

What foods should a woman eat and avoid before she gets pregnant? Why?

What medicines should she take and avoid before she gets pregnant? Why?

What foods should a woman eat and avoid when she is pregnant? Why?

What medicines should she take and avoid when pregnant? Why?

What foods should a woman eat and avoid in the first few days after giving birth? Why?

What medicines should a woman take and avoid during the first few days after giving birth? Why?

What foods should a woman eat and avoid in the first forty days after giving birth? Why?

What medicines should a woman take and avoid during the forty days after giving birth? Why?

What foods should a woman eat and avoid when she is breast feeding? Why?

What medicines should a woman take and avoid while breast feeding? Why?

What should a baby be given to eat in the first few days after birth? Why(not)?

Should the woman give the first milk to the baby? Why? If not, what is done with it? Why?

How long should a baby be breast fed?

What foods should a baby eat for the first six months? Anything other than mother's milk? Why?

What foods should the baby start to eat and at 6 months? Why?

What foods should a baby not start to eat at 6 months? Why?

What other foods should a baby girl / boy start to eat after a few more months (1 to 2 years)? Why?

Comment:

Would you like to learn about what foods the mother and baby should eat at different times so your children would be stronger and more intelligent?

Doesn't a father have any responsibility for helping his children grow up well?

## 10. HEALTH SEEKING FOR LAST ILLNESS OF YOUNGEST CHILD

(including alternative practitioners)

When was the last time your youngest child was sick?

Boy or girl? How old at the time?

What was wrong?

What caused it?

First: What was done first? -- eg: something at home? Given herbs?

What foods were given to the child? Why?

What foods were withheld from the child? Why?

Was the child cured? Why (not)?

Second:

Where was the child taken? Eg: a *mullah*? a hakim? CHW? BHC? pharmacy? other? Why?

Who decided where to go?

Did you require your wife to get permission to go to any of these healers? Why(not)?

What treatment and advice was given? What explanation was given?

Did you have to pay money? How much?

What foods were you told should be given to the child? Why?

What foods were you told should be withheld from the child? Why?

Did the child recover?

Third:

Where was the child taken next? Eg: a *mullah*? a hakim? CHW? BHC? pharmacy? other? Why?

Who decided where to do?

Did you require your wife to get permission to go to any of these healers? Why(not)?

What treatment and advice was given? What explanation was given?

Did you have to pay money? How much?

What foods were you told should be given to the child? Why?

What foods were you told should be withheld from the child? Why?

Did the child recover?

Continue with treatments until the child was cured

If the child is still sick, what will you do next? Why?

Should you do the same things for boys and girls when they have this sickness? Why(not)?

## 11. INTEREST IN AND POSSIBILITY OF LEARNING GROUPS WITHIN THE VILLAGE FOR WOMEN AND MEN

Would you like to join a group in the village?

How to help your children grow up stronger and smarter?

About preventing sickness?

About growing different / better food for your family?

Would you allow your wife and daughters to join a group?

For sewing together?

For learning more about taking care of children?

To learn about food, cooking, and health?

To learn about gardening, agriculture?

What other kinds of things would you like to learn more about?

## 12. WHAT CHANGES IN COMMUNITY DESIRED

What things are changing now in the village / community? Why?

Are these good? Why(not)?

What do you think about women's empowerment? Why?

If you could change something about your life / life in this village what would you like to change? Why?

## 13. LAST QUESTION ALWAYS:

What other kinds of things would you like to tell me?

What else should I have asked about?

THANK YOU VERY VERY MUCH!

BEFORE I GO, I'D LIKE TO SEE YOUR GARDEN, USE YOU TOILET, (then) WASH MY HANDS.  
PLEASE

## NUTRITION INTERVIEWS FOR PROVINCES

Anne Sweetser (with Kamal Burhan), Musarrat Arif, and Dr. Ludin at Provincial Level

Interviews with Ministry of Health / Public Health

Ministry of Agriculture home economics program

Ministry of Women's Affairs

Ministry of Rural Rehabilitation and Development

Senior provincial staff of NGO that is implementing BPHS

Senior provincial staff of other NGOs implementing gender and/or nutrition programs

Introduce this assessment –

On gender and nutrition

Very early study to advise USAID on effective project design

Multisectoral approach to nutrition production and consumption of more food and a greater variety of foods better access to and quality of health care improved water, sanitation and hygiene better access to and quality of education

Focus on gender constraints to implementing all of these sectoral initiatives effectively

Focus at the household level

Explain the team structure, how interviews are being done in cities and nearby rural areas In Badakhshan, Herat and Jalalabad Kabul, and Kandahar,

A: Program Description: (These should be covered quite quickly)

Program goals (medium and long term)

Activities being undertaken now

Cover whole province? Or certain districts?

Monitoring and evaluation schedule, format, people who do the work

Reporting – to whom?

Staffing – types, numbers

Funding sources(s)

Interconnections with other programs regular meetings?

Intersectoral engagement (eg: nutrition – health- education – WASH – agriculture)

B: Results: (might be quick, might take a bit more time)

Greatest successes (examples or very brief stories)

Challenges faced (explain)

Lessons Learned

Changes planned or under consideration

C: **MOST IMPORTANT**: Gender (Focus on these most of all!)

What social values, attitudes, and pressures within families affect women's and children's health?

What is the best way to reach women (especially in remote areas)?

What is the best place (own home, village, BHC etc.) to engage women?

How can a program best encourage women's involvement in a project?

How important is it to persuade men of the value of and offer them nutrition education?

In what way should men be engaged on reproductive health and child feeding issues?

What should the role of (male) elders and older women be in reaching younger women?

Should the mullah be involved? If so, in what way?

What role does a teacher play in village life and could he promote changes in caring for mothers and child feeding?

If school children were educated about nutrition, would this lead to changes in their homes?

How can emphasis in nutrition be shifted from treatment to prevention?

How effective are existing IEC materials?

How could they be improved or used more effectively?

How can media (especially radio and TV) be used effectively to reach men and women?

How important are demonstration projects?

How could they be improved?

How long should they be in order to be sustainable?

## Guideline for interviewing Save the Children or other project village volunteers

In addition to the standard household interview for men and women, please ask these questions too

### Women:

How did she learn about the STC program?

Why did she volunteer?

How long ago was the program held?

Was there resistance from men or mothers-in-law (or others)?

Ask her to please describe the whole program –

How the men's orientation was planned and carried out

How the men reacted

How she was trained

How the participants were chosen

What they did

Where they got the food that the group prepared

How the children benefitted

How her status within the village changed

Other things.....

Have other women in the village started feeding their children the same food?

Have women in nearby villages also started doing this too because they learned from this village? or because they had a training program too?

Has the nutrition situation of the all children in the village improved?

Does she think this is having / will have a long term effect?

Try to interview two more women who participated in the program  
(no more than half of your interviews in that village)

### Men:

Find at least two men who participation in the orientation session that STC ran to gain their permission for their wives (or daughters-in-law) to participate.

When did this take place?

Where was it held?

How many people came?

Who led it? What were they like?

What did they tell the men about malnutrition?

Did they learn enough or would they like to learn more about nutrition?

Why did they agree to permit their wives or daughters-in-law to participate?

How do they feel about the program now?

Other issues.....

## WOMEN – Question List

Explain that this is a study about women and children so more can be done to help children grow up healthier, stronger, and smarter. Explain you'd like to talk about their family and their children – while they do their work because you know they are very busy. Answer any questions they may have too. Try to keep the conversation with just the woman and other women in the house if unavoidable. Try using different types of questions

### FAMILY COMPOSITION

How many people live in this household?

Old men, old women, married men, married women, unmarried boys and men, unmarried girls and women, baby/infant boys, baby/infant girls?

If there is more than one married couple – how many people cook in separate kitchens?

If there is more than one kitchen, how many people eat from your kitchen? old men, old women, adult men, adult women, boys, girls, baby boys, baby girls?

Follow up on any comments (why two kitchens? why one person cooks for everyone?)

### ROLES OF MEN AND WOMEN WITHIN THE FAMILY

Re: old men in the family, older women, adult men, adult women, boys, and girls

Who does the shopping, and makes decisions about school for children, what food to eat, when and who the children should marry, what jobs each person should do?,

What is each (type of) person responsible for? Other comments?

How (if at all) are these roles changing?

What is causing these changes?

### 3. EDUCATION

How many of the boys / the girls go to school? Why(not)?

How many years should a boy / a girl go to school? WHY?

Did you ever go to school? How many years? Did you enjoy it? Do you remember??

What difference did this make in your life?

What is the most distant place you have visited? Why? Who decided?

How many times have you gone to [the provincial capital city]? Why? Who decided?

Do you have a mobile / telephone?

How many people in the family have a phone?

### 4. YOUR TIME USE

What do you typically do every day – these days / at this time of the year?

What things do you do first every morning? later morning?, early afternoon?, later afternoon?, evening?

What things do you do one or more days a week? When? How many days a week each?

Prompts:

Do you collect fire wood every day?

Do you rest for a while every day? When?

How often do you wash clothes? Iron clothes?

Carding or spinning wool?

Do you have time for sewing / knitting? / embroidery?

How much time do you spend exclusively taking care of children most days?

## 5. SEASONAL ACTIVITIES

Does anyone in the family earn wages or bring in cash income? How many people?

What does each of them do? (Might be a shop, day labor for public works, delivering things including water, agricultural work on others' crops, sewing, trading, small scale service jobs, driving, ??? )

Do they all contribute about the same amount? If not, what proportion does each contribute? for example: 60/40 or 70/30

How many people does each wage earner support?

### In the summer:

What field crops do you grow? Eg: wheat, rice, maize, clover alfalfa etc. (for animals)

What percentage do you sell, use to pay debt, keep for eating, keep for seed

What is the cash value of everything that is sold or used to pay debt?

What garden crops do you grow?

What percentage do you sell, use to pay debt, keep for eating, keep for seed

What is the cash value of everything that is sold or used to pay debt?

What tree crops (fruits and nuts) do you grow?

What percentage do you sell, use to pay debt, keep for eating, keep for seed

What is the cash value of everything that is sold or used to pay debt?

How many cows, oxen/bulls, camels, goats, sheep, chickens, others (what?) do you have?

What percentage do you sell, use to pay debt, keep for eating, keep for seed

What is the cash value of everything that is sold or used to pay debt?

Have you ever sold embroidery or other hand work?

How often have you done that? How much did you earn?

Do you ever decide what to do with money earned through your own efforts?

What agricultural and tree crop, gardening, and livestock work do old men, old women, men, women, boys, girls do?

Would you show me your fields, garden, trees, animals (later?), please?

### In the winter:

What do old men, old women, adult men, adult women, boys, girls do?

Who does these tasks: gathering wood, clearing snow from the roof, caring for livestock, getting water carding and spinning wool, making carpets. Other???

## 6. MARRIAGE

How old were you when you got married?

How old were you when you first got pregnant?

What (do people think) is the best age for a woman to get married? Why?

Who decides when girl should get married?

What (do people think) is the best age for a man to get married? Why?

Who decides?

What (do people think) is the best age for a woman to get pregnant for the first time? Why?

Who decides?

What (do people think) is the best number of boys? of girls? Why?

How much time is good between babies? Why? Who should decide?

Do you listen to the radio? Watch TV?

How long each time? Usually how many days a week?

When: morning / afternoon etc.?

Do you have a favorite program or two? Why is that / each your favorite?

#### 7. ANTENATAL CARE AND DELIVERY OF LAST CHILD (dead or alive)

During your last pregnancy how many times did you visit the CHW? midwife? BHC? etc

What advice were you given? Were you told why you should follow that advice?

What reason were you told?

Were you told anything about good and bad foods to eat? Why (for each?)

Were you told to take or avoid any medicines? Why?

Where did you deliver your last baby?

Who decided to go there?

Who helped?

#### 8. FOOD

How many times do you cook every day? Make bread? Make tea?

What did you cook today? Last night? ==> get 24 hours of food preparation history  
consumption patterns:

Does everybody eat at the same time? Or men first? Draw a circle or show a circle on paper  
– how much did the men eat of meals in the last 24 hours?

How was the rest divided among the rest of the people? How much did the women eat? the  
boys? the girls?

Draw another circle: When you have meat, how much do the men eat? the women the boys?  
the girls?

Why do men eat first?

Why is food divided this way within the family?

At what age do the boys start to eat with the men? Who decides?

How do you store any food that is left over after a meal? Why?

Are the women and children sometimes hungry? Why(not) ?

Do the men know if the women and children are hungry?  
What happens if you do not have enough food? (husband beats wife?)

What foods and medicines should a woman eat and avoid before she gets pregnant? Why?

What foods and medicines should a woman eat and avoid when she is pregnant?  
How much of it should she eat?  
How should it be prepared?  
Why?

What foods and medicines should a woman eat and avoid in the first few days after birth?  
How much of it should she eat?  
How should it be prepared?  
Why?

What foods and medicines should a woman eat and avoid in the first forty days after birth?  
How much of it should she eat?  
How should it be prepared?  
Why?

What foods and medicines should a woman eat and avoid when she is breast feeding?  
How much of it should she eat?  
How should it be prepared?  
Why?

What should a baby be given to eat in the first few days after birth? Why(not)?  
Should the woman give the first milk to the baby? Why?  
If not, what is done with it? Why?  
How long should a baby be breast fed?

What foods should a baby eat for the first six months? Anything other than mother's milk?  
How much? How often?  
How prepared?  
Why?

What foods should the baby girl / boy start to eat starting at 6 months?  
How much? How often?  
How prepared?  
Why?  
What foods should a baby not start to eat starting at 6 months? Why?

What other foods should a baby girl / boy eat when 1 to 2 years old?  
How much? How often?  
How prepared?

Why?

## 9. HEALTH SEEKING FOR LAST ILLNESS OF YOUNGEST CHILD

(including alternative practitioners)

When was the last time your youngest child was sick?

Boy or girl? How old at the time?

What was wrong?

What caused it?

First: What did you do? -- eg: something at home? Give herbs? Why?

What foods did you give to the child? Why?

What foods with you withhold from the child? Why?

Was the child cured? Why?

Second:

Who did you go to? Eg: a mullah? a hakim? CHW? BHC? pharmacy? other?

Why?

Who decided where to do?

Did you have to get permission to go to any of these healers? Why?

What treatment and advice were you given? What explanation was given?

Did you have to pay money? How much?

Were you told to give the child certain foods? Why?

Were you told to avoid giving certain foods to the child? Why?

Did the child recover?

Third:

Who did you go to? Eg: a mullah? a hakim? CHW? BHC? pharmacy? other? Why?

Who decided where to do?

Did you have to get permission to go to any of these healers? Why?

What treatment and advice were you given? What explanation was given?

Did you have to pay money? How much?

Were you told to give the child certain foods? Why?

Were you told to avoid giving certain foods to the child? Why?

Did the child recover?

Continue with treatments until the child was cured

If the child is still sick, what will they do next? Why?

Should you do the same things for boys and girls when they have this sickness?

Why(not)?

## 10. WASH

*Water*

Where do you get your water? (river, pond, well, pump, standpipe, in-house faucet)

Do you carry it?  
Who helps? (boys? girls?) Why(not)? Is this fair?  
How far do you carry it?  
How many times a day do you get water?  
What containers do you use?  
Is it delivered?  
Who delivers it?  
How many times a day?  
Do you have to order it each time?  
How do they deliver it? (carry, cart, donkey?)  
How much do they bring each time?  
How much does it cost - per amount delivered?  
Is the water clean?  
If not, what is wrong with it? -- dirty, cloudy, smelly, funny tasting etc.?  
Do you treat it? How?  
Where do you store water?  
What do you do with used water? (throw it?, drain?, put on garden?, use it for something else, like washing clothes?)  
What do you do with food scraps? Waste paper? Plastic (bags and bottles etc.)?

### *Sanitation*

Do you have a latrine? a toilet? flush type? What other do you use?  
Is it in the house? Or how far away is it?  
If it is outside, can a woman go at any time during the day?  
Does a woman avoid drinking water so she doesn't have to go too often?  
What if she is sick? Especially if she has diarrhea? What can she do?  
Is it safe at night for a woman to go at night? For a man?  
What causes the danger? People? Spirits?  
What should be done if men harass the women? Probe!

### *Hygiene*

Where do you wash your hands?  
So you always use soap?  
How often do you wash your hands?  
At what times do you wash your hands (after toilet, before cooking, before eating etc.)

## 11. INTEREST IN AND POSSIBILITY OF GROUP ACTIVITIES FOR WOMEN WITHIN THE VILLAGE

Would you like to join a group of women in the village?  
For sewing together?  
For learning more about taking care of children?  
To learn about food, cooking, and health?  
To learn more about gardening, agriculture?  
What other kinds of things would you like to learn more about?

Who decides (gives permission) if you can join?

Do you think you would be given permission to join? Why(not)?

12. WHAT CHANGES IN COMMUNITY DESIRED

What things are changing now in the village / community? Why?

How has this affected men's and women's lives?

If you could change something about your life / life in this village what would you like to change? Why?

13. LAST QUESTION ALWAYS: What other kinds of things would you like to tell me?

What else should I have asked about?

THANK YOU VERY VERY MUCH!

BEFORE I GO, I'D LIKE TO SEE YOUR GARDEN, USE YOU TOILET, (then) WASH MY HANDS. PLEASE

## ANNEX VII: DISCLOSURE OF ANY CONFLICTS OF INTEREST

[The Evaluation Policy requires that evaluation reports include a signed statement by each evaluation team member regarding any conflicts of interest. A suggested format is provided below.]

<b>Name</b>	Anne T. Sweetser
<b>Title</b>	Team Leader
<b>Organization</b>	Social Impact / Checchi Consulting
<b>Evaluation Position?</b>	<input checked="" type="checkbox"/> Team Leader <input type="checkbox"/> Team member
<b>Evaluation Award Number</b> <i>(contract or other instrument)</i>	
<b>USAID Project(s) Evaluated</b> <i>(Include project name(s), implementer name(s) and award number(s), if applicable)</i>	
<b>I have real or potential conflicts of interest to disclose.</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p><b>If yes answered above, I disclose the following facts:</b> <i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> <li>1.     <i>Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.</i></li> <li>2.     <i>Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.</i></li> <li>3.     <i>Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.</i></li> <li>4.     <i>Current or previous work experience or seeking</i></li> </ol>	

<p><i>employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.</i></p> <p>5. <i>Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.</i></p> <p>6. <i>Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.</i></p>	
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I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

<b>Signature</b>	
<b>Date</b>	November 4, 2014

**Cecchi and Company Consulting, Inc.**  
**Afghanistan SUPPORT-II Project**  
**Wazir Akbar Khan**  
**Kabul, Afghanistan**