BASELINE ASSESSMENT ON MATERNAL NEW BORN AND CHILD HEALTH IN DISTRICT TWO OF KABUL CITY, AFGHANNISTAN

ASSESSMENT REPORT

KAP survey and FDGs to help Care International modify its MNCH project based evidence the survey also provide a base to measure change over time.

1/7/2016

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EXECUTIVE SUMMARY

Kabul, the capital city of Afghanistan with four millions people(Centeral Statistics Office, 2015- 2016), has faced particularly huge difficulties. The continuing influx of migrants has generated numerous illegal residents, which is estimated to account for 80 percent of the entire city's population(JICA, 2013). Most of them are so-called "urban poor," and they have no access to health care except for public health facilities where the services are provided for free. International Care has been implementing community based Maternal, New-born and Child Health (MNCH) project in district 1. Recently, Care International started to expand its program to district 2 of Kabul city.

As part of the on-going efforts to address the mothers and children health issues, there is need to better understand the myriad factors that influence access, demand and utilization of healthcare service in district 2 of Kabul city. The on- going Care International project in 2nd district of Kabul city , can only be effective, equitable and achieve value-for- money if they are informed and guided by an understanding of the demand-side factors including the knowledge, attitudes and practices of the targeted beneficiaries.

The KAP survey aimed to identify knowledge gaps, attitude patterns, and practices that may facilitate understanding and action or create barriers to Maternal, New-born and Child Health (MNCH).

A Cross-sectional descriptive study design was utilized to provide information on key knowledge, attitude and practice variables related to maternal, newborn and child health with 375 household in 2nd district.

Among others, the following are the key findings of the survey:

1. High total fertility rate,
2. Low uptake of family planning/ birth spacing methods, especially long term methods,
3. High drop outs in routine vaccinations
4. High level of pregnancy complications
5. High level of miscarriage, abortion and children death after birth.
6. High delivery related risks and
7. Low level of delivery preparedness

8. Low ANC services uptake.
9. Considerable knowledge gaps and misconceptions regarding some aspects of MNCH

Recommendations from this assessment include:

1. The need to empower communities on MNCH by providing information on the various components of MNCH
2. There need to strengthen the health system so as to improve access and quality of services in tandem with improved demand as health awareness increases.
3. A mix of channels to be used in delivery of key MNCH messages with a focus on oral means of communication.

INTRODUCTION

Despite health system achievements in rural areas, people living in urban areas have been marginalized from this increase in access to health care. Relatively better conditions in urban areas, such as existing health facilities including private ones, have diverted both the government's and donors' attention away from the health situation in the cities. As a result of being considered as "less serious", these urban areas have been left uncovered by BPHS although the population also suffers severe shortcomings in health care service delivery.

Kabul, the capital city of the country with four millions people, has faced particularly huge difficulties. The continuing influx of migrants has generated numerous illegal residents, which is estimated to account for 80 percent of the entire city's population. Most of them are so-called "urban poor," and they have no access to health care except for public health facilities where the services are provided for free. International Care has been implementing community based Maternal, New-born and Child Health (MNCH) project in district 1. Recently, Care International started to expand its program to district 2 of Kabul city.

Therefore, Care International commissioned a consultant to pursue a base line assessment to generate information that will be used as base line for its current community based Maternal, New-born and Child Health project.

The baseline assessment was undertaken in form of Knowledge, Attitude and Practices (KAP) survey. The survey aimed to identify knowledge gaps, cultural beliefs or behavioral patterns, practices which can facilitate understanding and action or create barriers to MNCH care.

KAP survey also assessed the communication processes/channels that are appropriate in promoting uptake of MNCH services and positive behavioral practices among communities in mentioned district.

The survey had below specific objectives:

1. To collect data related to the indicators in the project indicators that will serve as the basis for monitoring the project and measuring the changes;
2. To determine existing levels of knowledge, attitudes and practice towards MNH and access to Ministry of Health- MOH services in the targeted communities.

3. To capture basic demographic variables including respondents' education, age, as well as living children.

METHODOLOGY

The baseline assessment was undertaken in2nd district of Kabul city. 2nd district of Kabul city is a populated urban area and its residents has limited access to public health care facilities. A Cross-sectional descriptive study design was used to provide information on key knowledge, attitude and practice variables related to maternal, newborn and child health.

SURVEY

SAMPLING

Households Sampling: Cluster sampling was used. Using fisher et. Al. formula a sample size of 341 households was attained. The assessment utilized two-stage cluster random sampling where the primary sampling units were communities and secondary sampling unit were households within the sampled communities. At both stages, a simple random sample was picked. To compensate for non-response rate an additional 10 % of sample population were also interviewed. The respondents inclusion criteria include married women of reproductive age (14-49) living in district 2 of Kabul city. Below formula was used for sample size calculation:

$$SS = \frac{Z^2 * (p) * (1-p)}{C^2}$$

THE SURVEY INSTRUMENT

The survey team used a semi structure questionnaire to capture the information. The questionnaire had three general sections; informed consent and introduction, demographic information, and main questions. It comprised 44 multiple choices, categorical, and agree/disagree questions(USAID, 2013). The questionnaire is attached in annex-1

FOCUS GROUP DISCUSSIONS

For the Focus Group Discussions (FGDs)a purposive sampling was used to allow selection of appropriate respondents. A total of three focus group discussions were undertaken with women, men. Focus group discussions were held separately for both genders to overcome any potential bias due to gender dynamics. A FGD guide was used to guide the discussions. A FDG guide is attached in annex -2.

DATA MANAGEMENT

The coded answers were analyzed using Statistical Package of Social Sciences (SPSS) computer software. Analysis of categorical and nominal data is presented as percentages and frequencies while mean and range are analyzed and presented for continuous variables. All qualitative data was transcribed verbatim, coded and organized into themes. Building on emerging themes, the qualitative data was triangulated with quantitative data from the households.

The following measures were taken to ensure survey data was of utmost quality:

1. Translation of survey instrument into local language (Dari)
2. Training of survey team on data collection tool and survey techniques
3. Testing of survey instrument by piloting it during survey team training.
4. Spot checks on survey team during data collections in the field.
5. Daily checking of completed survey instruments by survey supervisors
6. Completeness and validity check of a sample of filled survey instruments by the consultant.

ETHICAL/ADMINISTRATIVE CONSIDERATIONS

The following ethical/administrative procedures were adhered to before and during the KAP survey:

1. Informed consent: Every respondent was duly informed of the purpose and contents of the interviews and their consent sought before proceeding. The respondents were assured of their right to refuse to answer all or any specific questions.
2. Privacy: Interviews were conducted in a manner that was comfortable to respondents and their right to privacy was respected.
3. Confidentiality: The respondents' were assured of confidentiality and their names or other identifying information was not required for this survey.

FINDINGS

RESPONDENTS' CHARACTERISTICS

The survey team reached to 375 respondents during KAP survey. This represents a 100 % response rate. 78 % of respondents aged from 16 to 35 years and indicating younger population with mean age of 29 years. The level of education attainments poor. More than 56 % of respondents have no education at all and only 3.45 completed universities. The table -1 summarizes the respondents' age distribution, mean number of living children, and educational attainment.

	Percentage or mean value
Age	
16-25	37.37%
26-35	41.67%
36-45	20.96%
Mean age	29
Mean number of living children	3.9
Education	
No Education	56.96%

Preschool not completed	4.56%
Primary school not completed	7.85%
Primary school completed	9.37%
Secondary school not completed	7.09%
Secondary school completed	9.11%
University completed	3.54%
Vocational training	1.52%

Table 1: Percentage distribution or mean value of respondents' characteristics in district 2 of Kabul city

REPRODUCTIVE HEALTH

ANTENATAL CARE (ANC)

In Knowledge, Attitude and Practice (KAP) Survey, women were asked whether they received Ante Natal Care (ANC) during last pregnancy and if yes, how many visits they attended.

65.21 % of respondents, aged 16 to 25 years old received one ANC visit from a skilled provider and 38.89 % completed all four visits (Table 1). It is obvious, the frequency of first ANC visit within this age category is relatively high but a smaller group completed all four required visits. The occurrence of four ANC visits completion further declines to 18.33 % in age category 36 to 45. This dramatic decline describes that many women making first ANC later in their pregnancies, basically, when a problem occurs rather than making it earlier as a routine visit.

Furthermore, women with secondary or university education were more likely to receive ANC services. The frequency of first ANC visit in this category varied from 71 to 82% but in women with no education and less than secondary education ranged from 59.70 to 65.24%.

Despite mentioning above, the level of education did not influence completion of all four visits. Finally, the number of living children did not have noteworthy influence on both first and four ANC visits completion status.

Characteristics	Any ANC visit	At least four ANC visits
Age		

16-25	65.21%	38.89%
26-35	69.12%	42.78%
36-45	61.01%	18.33%
Number of living children		
0	59.43%	28.57%
1	65.55%	24.07%
2	68.28%	30.00%
3	64.00%	28.81%
4	65.33%	23.52%
5 and more	61.24%	22.52%
Education		
No Education	61.70%	35.22%
Preschool completed	68.24%	37.25%
Primary school not completed	71.00%	41.14%
Primary school completed	70.22%	45.16%
Secondary school not completed	72.31%	47.00%
Secondary school completed	73.18%	52.50%
University	95.00%	58.57%

Table 2: Percentage of women who received any Ante Natal Care (ANC) from skilled provider, received at least four ANC visits during last pregnancy, by respondents' age, number of living children and level of education.

Women who had utilized ANC services during their last pregnancy were asked who, in terms of gender, had examined them. A majority (93%) of the ANC clients were examined by a female health worker while 7% were examined by a male health worker. Almost all of the respondents preferred a female health worker to examine them.

GIVING BIRTH AT A HEALTH-CARE FACILITY

Women's attitudes about giving birth at health facilities varied. While majority indicated as they selected health care facility because of adequate skills of health workers in health facility (85.38%), adequate privacy health facility (75.70%) and availability of medicines and equipment to make a safer

delivery (71.36%) but limited number of respondents agreed so their delivery would be assisted by a male health workers.

Attitude toward giving birth at health facility	Agree	Disagree	Don't know
The health workers at the health facility are adequately skilled	85.38%	11.03%	3.59%
The health facility has adequate privacy	75.70%	5.88%	5.88%
The health facility has all the medicines and equipment to make delivery safe	71.36%	8.95%	8.95%
There is no problem even if the health worker assisting the delivery is a male.	19.39%	71.43%	9.18%

Table 3: Percentage of women agree, disagree or don't know to give birth in a health facility.

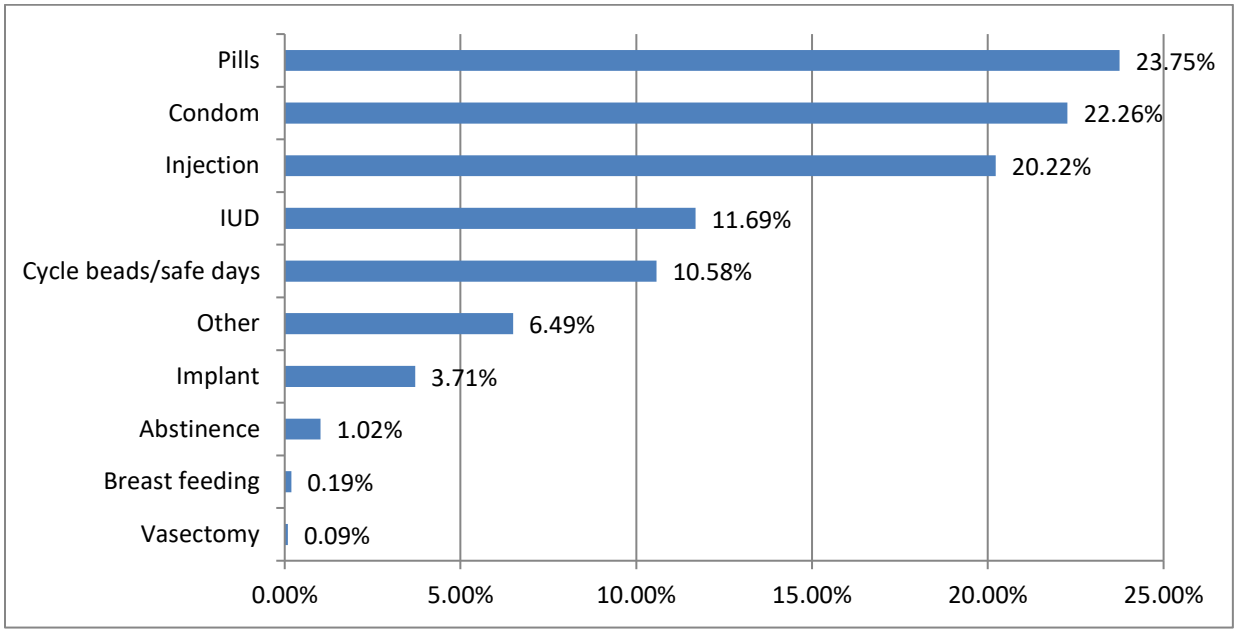
BIRTH SPACING METHODS

Significant variations were also noticed on the knowledge on various methods of birth spacing among respondents. A high number of women (23.75%) reported to have knowledge on pills as a way of birth spacing followed by condoms (20.22%) and then injections (22.26%).

From the assessment however there is clear evidence that knowledge on long term methods of birth spacing was minimal, if not lacking, respondents recorded less than 5 % for sterilization and implants.

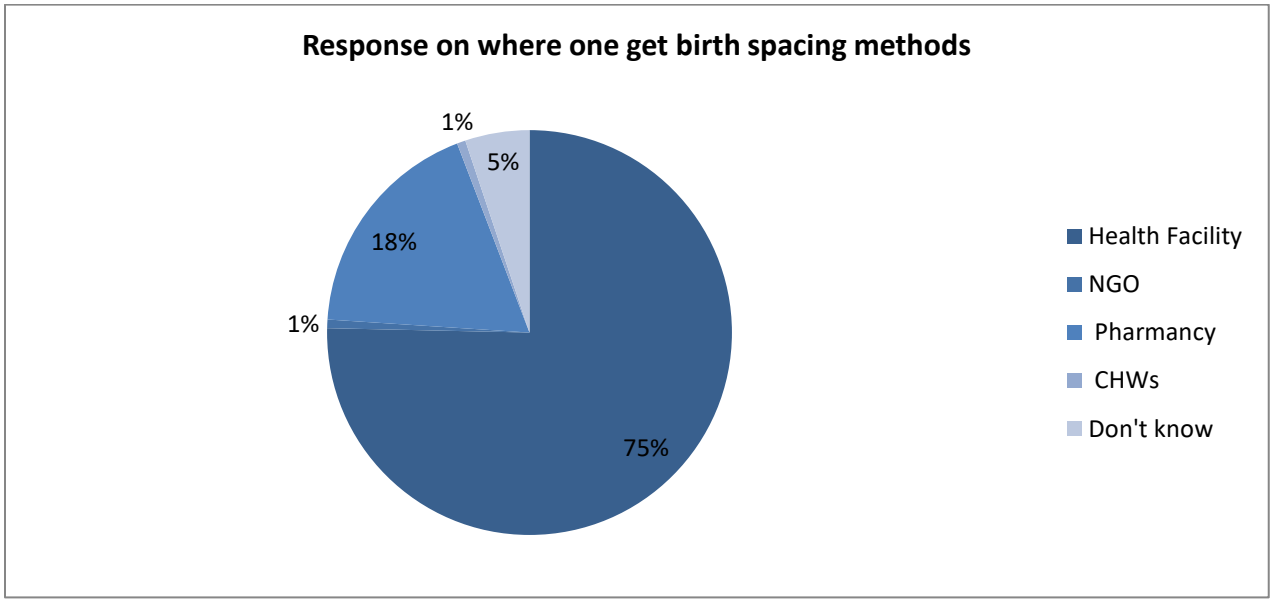
Women were asked if they had ever used a contraceptive method to delay or avoid pregnancy and whether they were currently using a method. Overall, 55.11 % of respondents reported as ever wished use a contraceptive method and 31.44% reported actual use.

Figure 1: Knowledge on different methods of birth spacing (multiple answers)



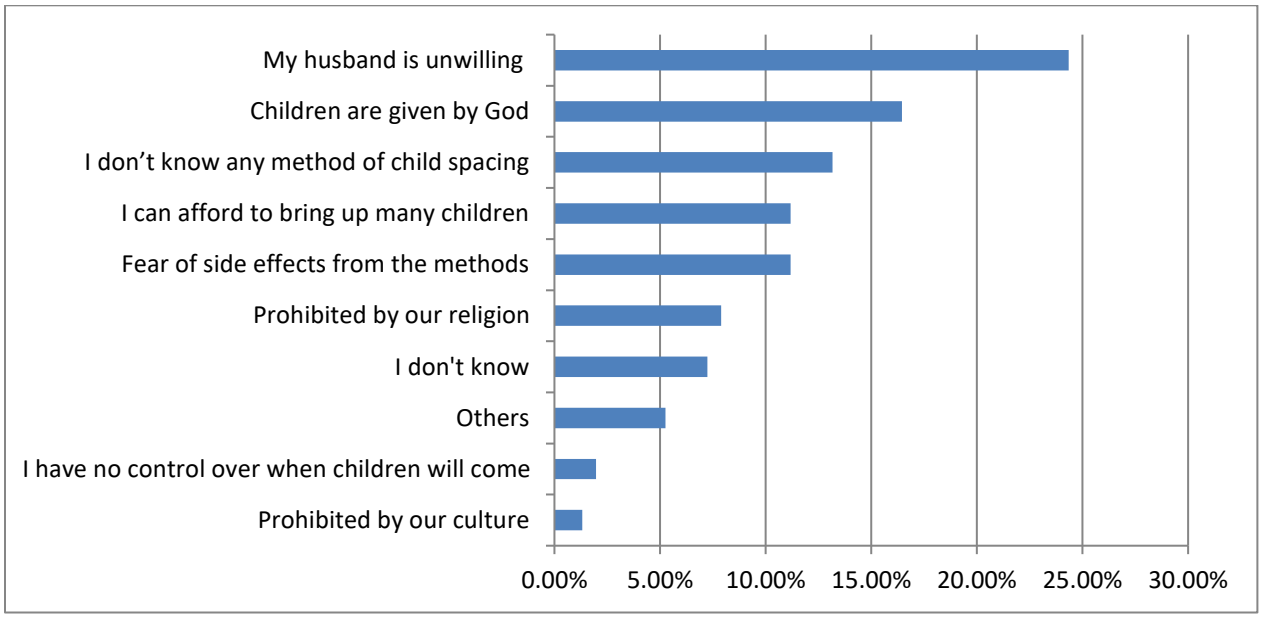
Knowledge on places where one can get modern birth control methods in their community re- corded less than half of the respondents. Health facility was the most reported place at 75% with pharmacy shops and CHWs recording less than 10% as shown in the figure below.

Figure 2: Places where to get birth spacing methods



For the majority of respondents who reported having never used any birth spacing method, the main reasons given were that their husbands are unwilling (24.34%) , children are given by God (16.45%)or because they did not know any birth spacing method (13.16%). The rating for all reasons not using any birth spacing method is shown in figure below:

Figure 3: Reasons for not seeking ANC during last pregnancy

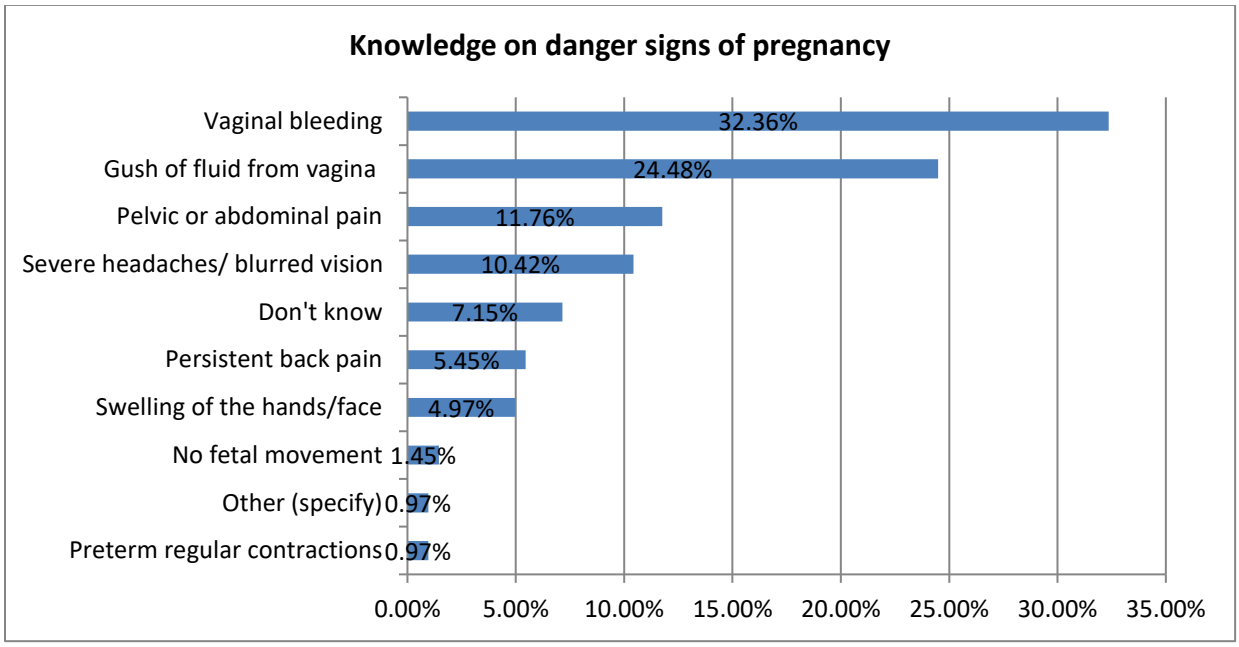


DANGER SIGNS IN A PREGNANCY

The assessment sought to establish knowledge level on danger signs during pregnancy. Approximately, all respondents gave an answer (almost 36.06 % of them, giving more than 2 symptoms). The respondents' knowledge on danger signs of pregnancy were measured as: Vaginal bleeding (32.36%), gush of fluid from vagina (24.48%) and pelvic and abdominal pain (11.76%).

Less than (10%) respondents knew about persistent back pain, swelling of hands/face, no fetal movement, and pre term regular contraction.

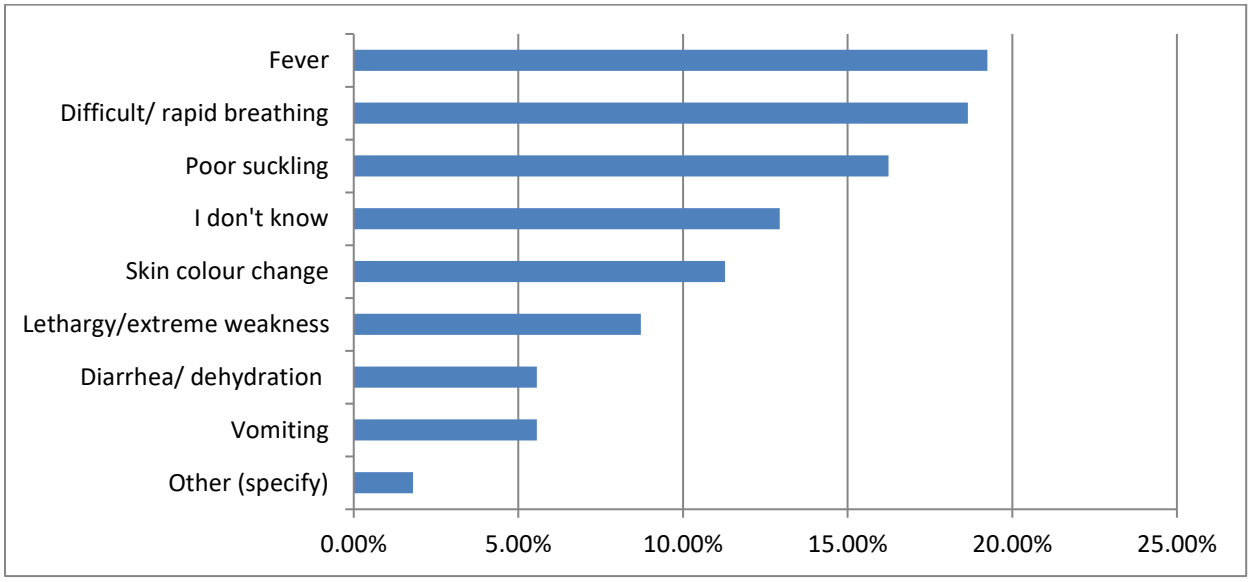
Figure 4: Knowledge on danger signs of pregnancy



DANGER SIGNS IN NEWBORNS

The most mentioned symptom was fever (19.25%) followed by difficult /rapid breathing (18.65%), poor suckling (16.24%) and skin color change (11.28%). Less than 10 % mentioned vomiting, diarrhea and dehydration and extreme weakness.

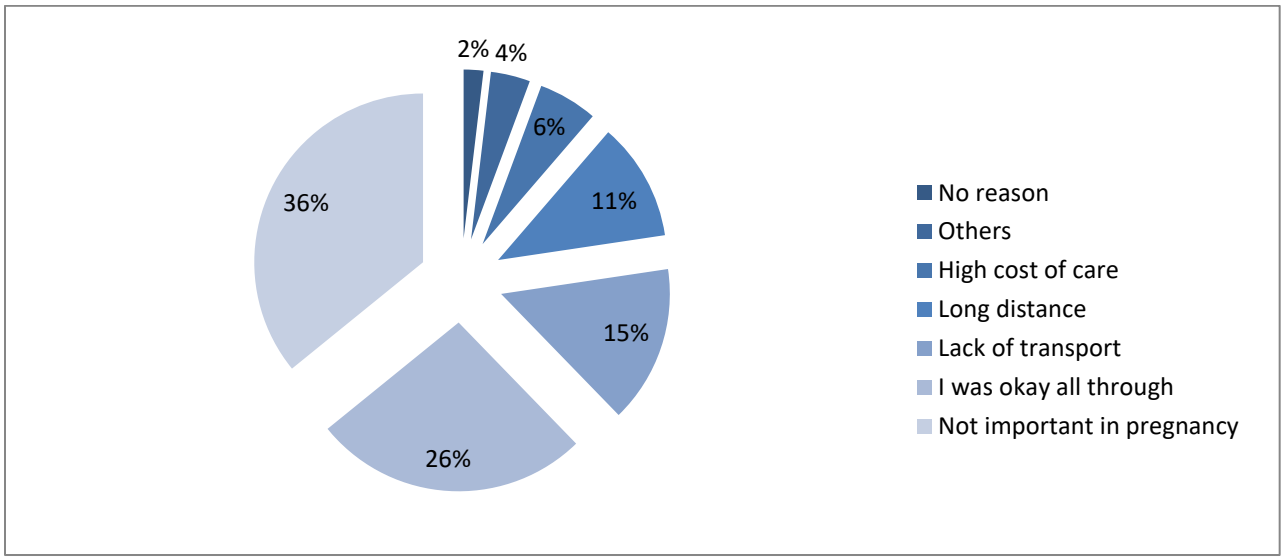
Figure 5: Knowledge on new born danger signs (multiple answers)



UPTAKE OF ANTENATAL CARE (ANC)

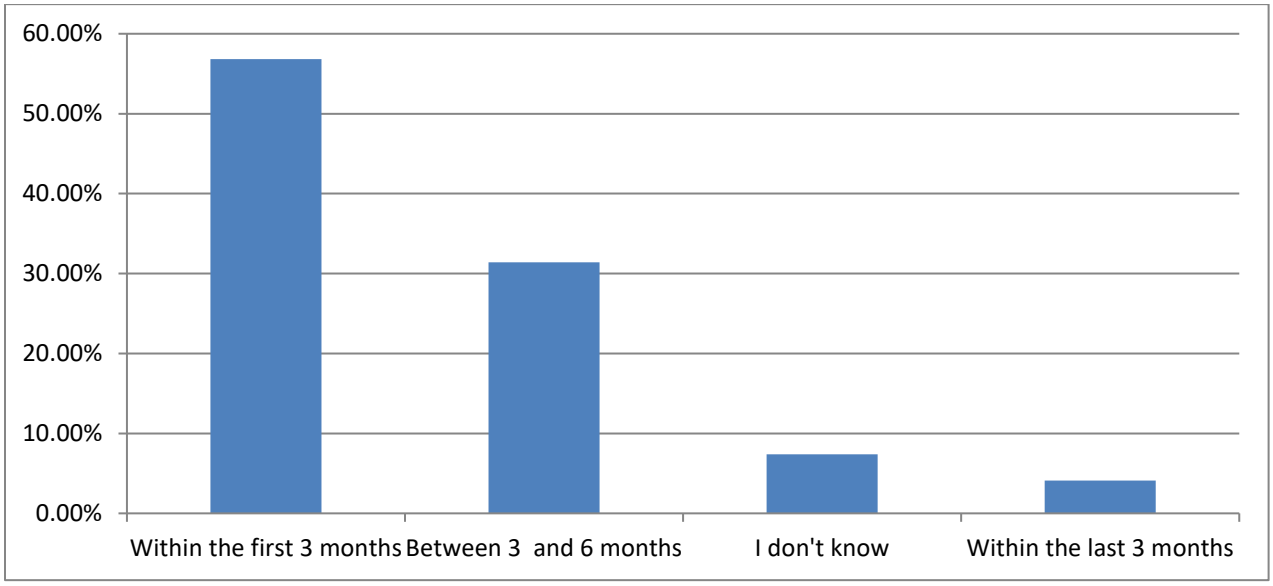
Majority (66.56%) of women who had ever been pregnant reported to have taken up antenatal care services during their last pregnancy. For the remaining 33.44 % the reasons for not taking up the ANC services varied from no reasons to cost of transport and lack of knowledge on its importance. The reasons for not taking ANC are shown in figure below.

Figure 6: Reasons given for not wishing to delay the birth of children



The number of ANC visits during pregnancy and the timing of the first visit were also assessed. The World Health Organization (WHO) recommends a minimum of four antenatal visits with the first visit being within the first trimester. The survey found out that only 33.44% of respondents had made at least four ANC visits during their last pregnancy. As evident from the bar chart below, delay in taking up ANC services was also a problem as only 30% of the respondents made their first ANC visit within 3 and 6 months.

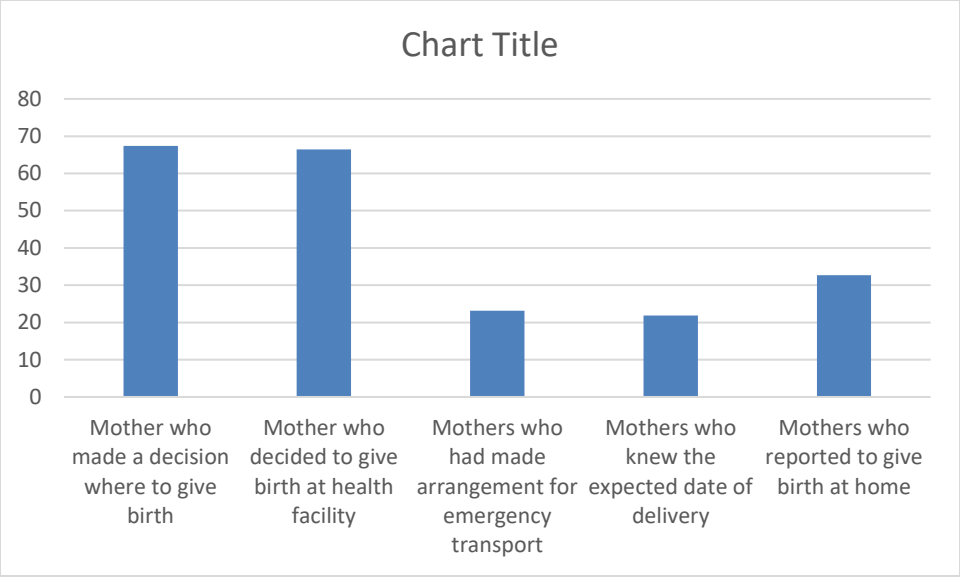
Figure 7: Timing of ANC visit during pregnancy



BIRTH PREPAREDNESS DURING LAST PREGNANCY

More than two quarters (67.34%) had made the decision on where to give birth and 66.46% planned to give birth in a health facility but only (23.12%) reported to have made arrangements for emergency transport. The lack of arrangements for emergency transport could further explain why (32.66%) reported to have given birth at home. Almost less than half (31.9%) of mothers who had given birth knew the expected day of delivery.

Figure 8 decision where to give birth

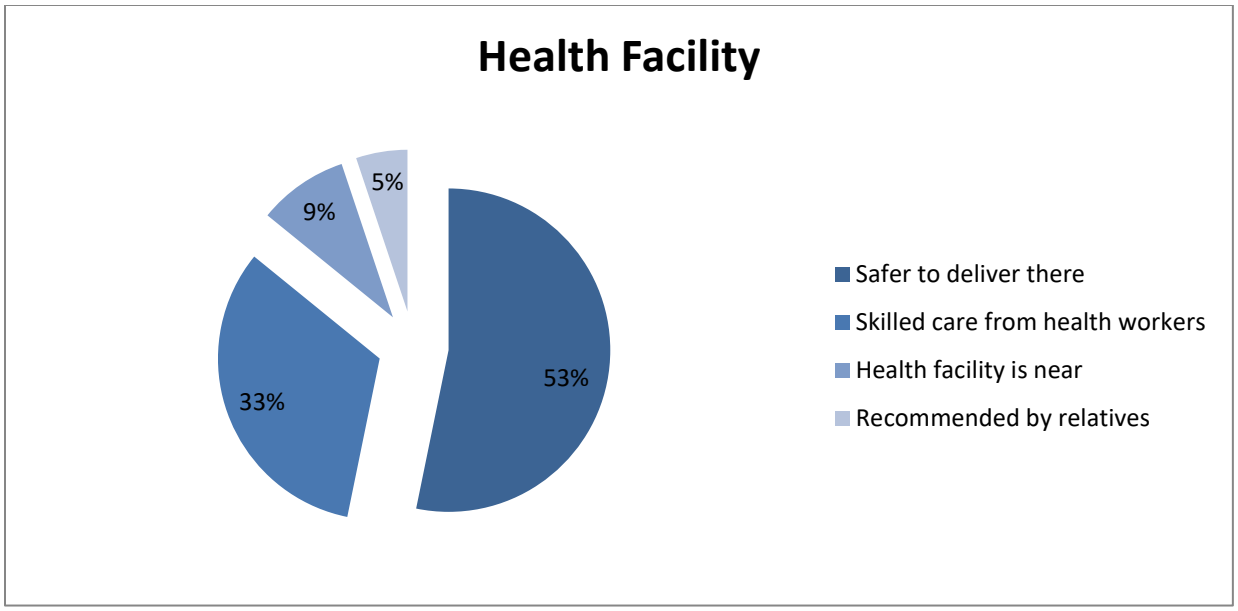


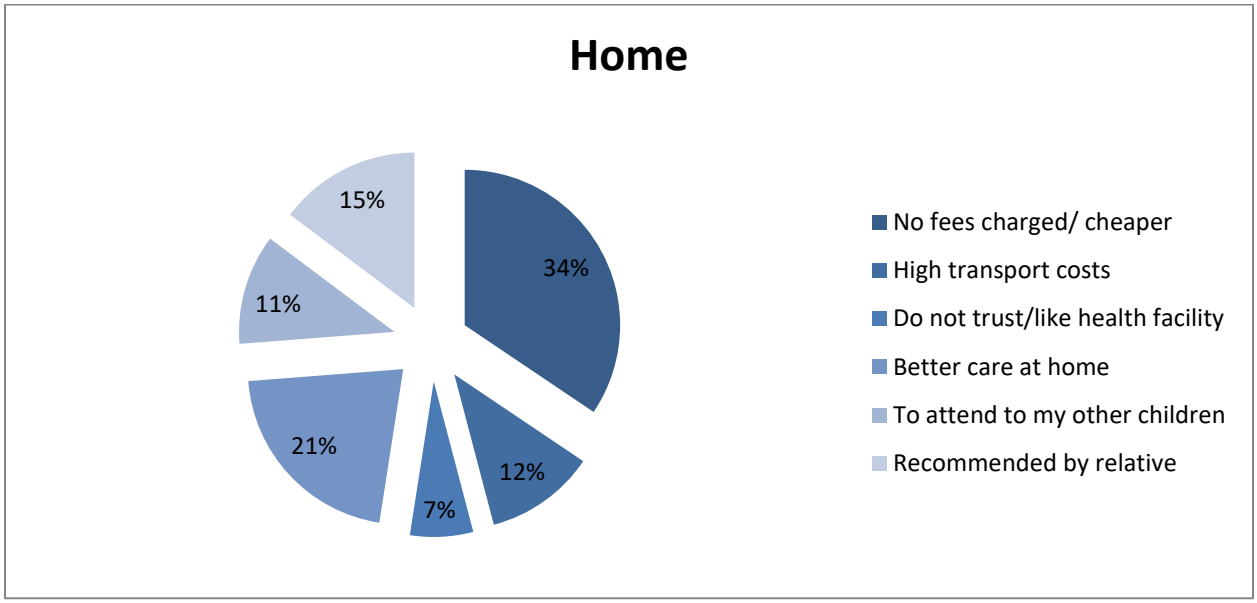
PLACE OF BIRTH

The final decision on where a woman will give birth was found to be largely made by women's husband or women's in laws as 35.76 and 35.96 % respectively during last child birth. However 24.15 % reported that the decision was made by them, the decision on whether to give birth at a health facility or at home was influenced by husband and in laws.

The selection of health facility was predominately influenced by safety, the desire for skilled deliveries, proximity to the woman's home while delivery at home was preferred for reasons such as " no fees charged, high transportation cost, to be able to attend to other children, and not trusting health facility"

Figure 9: Reasons for preference to give birth at home or health facility



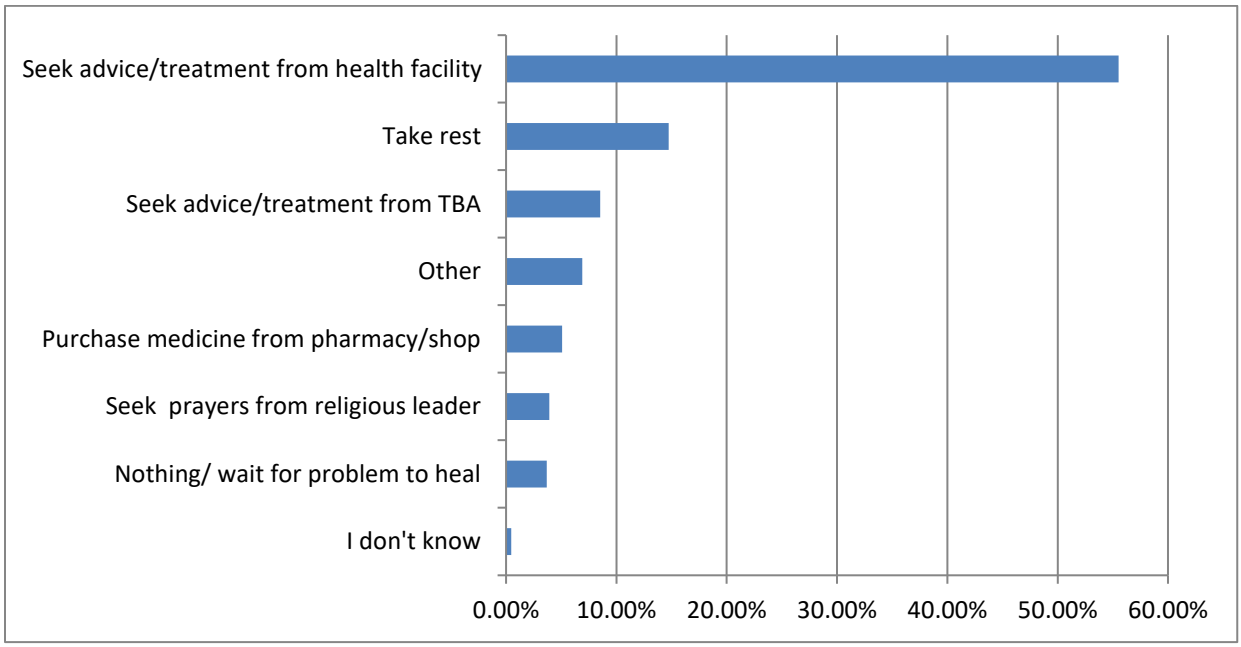


The information above on factors influencing why mothers choose to give birth at home were corroborated by key informants who stated that women prefer home-delivery in order to take care of their other children and attend to their other household chores.

RESPONSE TO DANGER SIGNS DURING PREGNANCY

A high proportion (41.28%) of women reported having experienced one or more of the danger symptoms during their last pregnancy. Though when that happened, the predominant action was to seek treatment from a health facility (55.53%). Almost, (14.75%) took rest, (8.53%) took advice from CHW or TBA and 3.69% reported to have done nothing substantive.

Figure 10: Actions taken when experienced danger signs during last pregnancy



After noticing the danger symptoms, 72.99 % of the women took action within 12 hours while 11.17 % and 4.28 % took action after 12 to 24 hours and after more than 24 hours respectively.

It is shocking that almost a third (33.33%) of respondents who have ever been pregnant reported either having ever had a miscarriage, spontaneous abortion or still birth or a child that died after birth.

BREASTFEEDING PRACTICES

Breastfeeding is one of the most effective ways to ensure child health and survival. The WHO recommends that breastfeeding should be initiated within the first hour after birth and exclusive breastfeeding be done up to 6 months of age. This survey sought to find out the level of knowledge, attitude and practice to these two “gold standards”.

Women who had given birth were asked after how long they breastfed their babies after birth. 66.93% of respondents reported having done so within the recommended 1 hour and (25%) after two hours. The survey found out that the main reasons for not started within recommended hour (49.12%) was perception that the mother was unwell after delivery and needed time to recover before breastfeeding. There was also references to the notion that breasts had no milk at the early stage, early initiation of breastfeeding is a taboo, the misconception that colostrum was not good for baby. The table below presents these findings.

Reasons for not giving breast milk within first hour	Percentage
Mother was unwell	49.12%
Breast not producing milk	26.32%
Colostrum not good for baby	13.16%
Taboo	5.26%
I don't know	4.39%
Others	1.75%

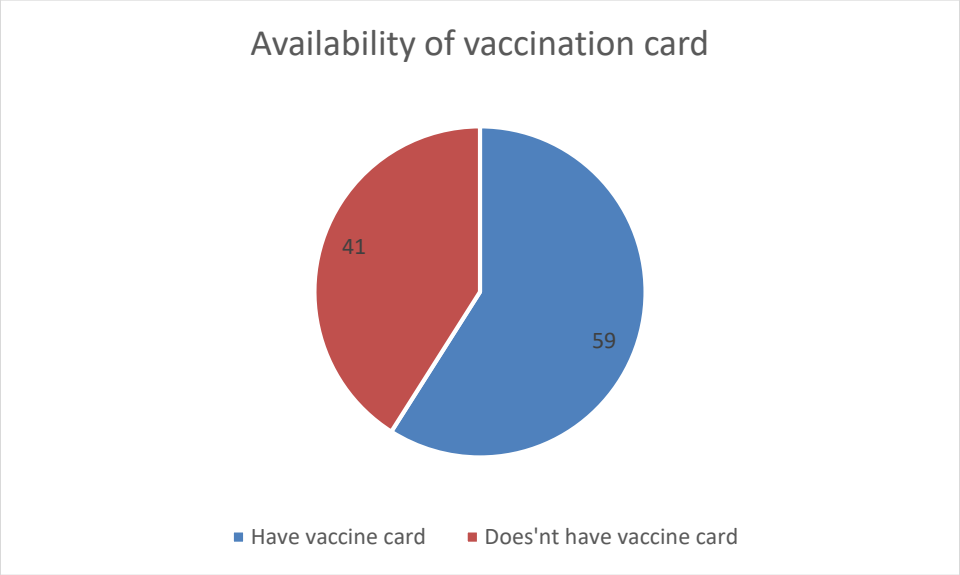
Table 4: Reasons for not giving breast milk within first hour.

Less than half of (46.36%) respondents started supplementary feeding for their children after six months. There were a few women (2.62%) who reported giving alternative food/ drinks to newborns soon after delivery. In the focus group discussion with women, it emerged that women had wrong beliefs that in the first 3 days of life, there is no milk in the breast; hence there is no need to put the child on the breast. They also believe that colostrum is bad for a child's health as it is too concentrated and makes the child sick.

IMMUNIZATION UPTAKE

The assessment sought information on whether the last born child had received all the vaccines due at their age. Two methods were used, the survey team scrutinized the child health card and where the card was not available a series of questions were asked to determine the immunization status of the child. The child heath card was only available in 59 % of the households.

Figure 11: Immunization status of last born child



The findings indicate that only 59.9 % of the children with immunization cards and 11.09 % without vaccination card under survey were fully immunized as per their age. It is evident that the coverage has declined progressively with doses and age of child. For instance, the coverage of OPV 1 and DPT 1 tended to be higher than OPV 3 and DPT 3 respectively. This finding is suggestive of progressive dropout and high defaulter rate. The table below presents these findings.

Vaccines	With vaccination card	Without vaccination card
BCG	73.68%	63.06%
OPV1	83.70%	78.23%
OPV2	76.67%	72.69%
OPV3	62.12%	78.00%
DPT1	71.79%	66.13%
DPT2	48.49%	46.13%
DPT3	41.89%	44.06%
Measles	54.02%	64.41%

Table 5: immunization coverage

Mothers were asked to give reasons why they had not taken their children for immunization, or why they had defaulted. As summarized in the table below, majority of the reasons depict lack of adequate knowledge or poor attitude towards immunization.

Reasons	Percentage
My family does not allow	22.92%
Immigration	22.92%
Lack of information about vaccination	14.58%
Others	14.58%
Health facility is too far	12.50%
Child fall ill with vaccination	12.50%

Table 6: Reasons for not immunization the last child

In focus group discussion below reason were indicated for not taking their children for vaccination:

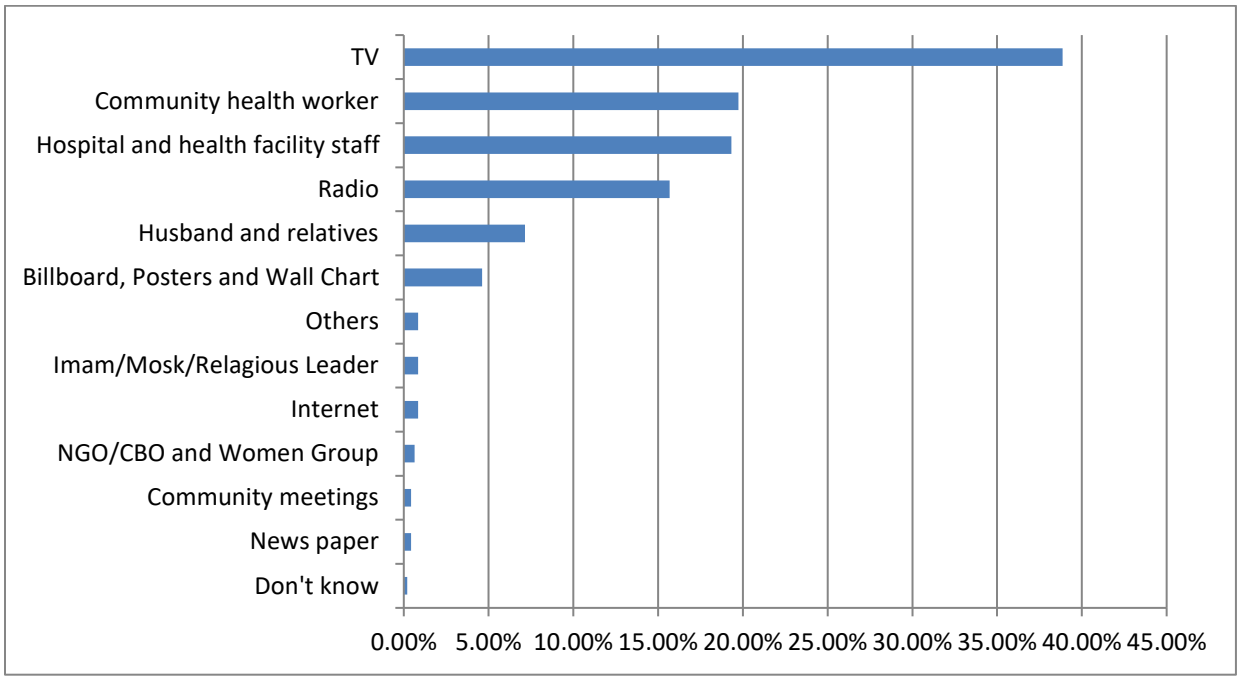
1. Misbehavior of health facility staff
2. Mother was sick
3. No one to take care of her other children
4. Vaccination card was lost
5. Does not like vaccination
6. Crowded health facility
7. Mother does not have time

SOURCES OF MNCH MESSAGES

The assessment sought to establish existing messages and channels of information on MNCH. In the three months preceding the assessment, slightly more than half (68.11%) of women heard or read messages on health of mothers and children. Asked which messages they had received, 38.11% received messages on hygiene, on 26.67% immunization, 25.33 % on ante natal care and 5.07 % on specific disease.

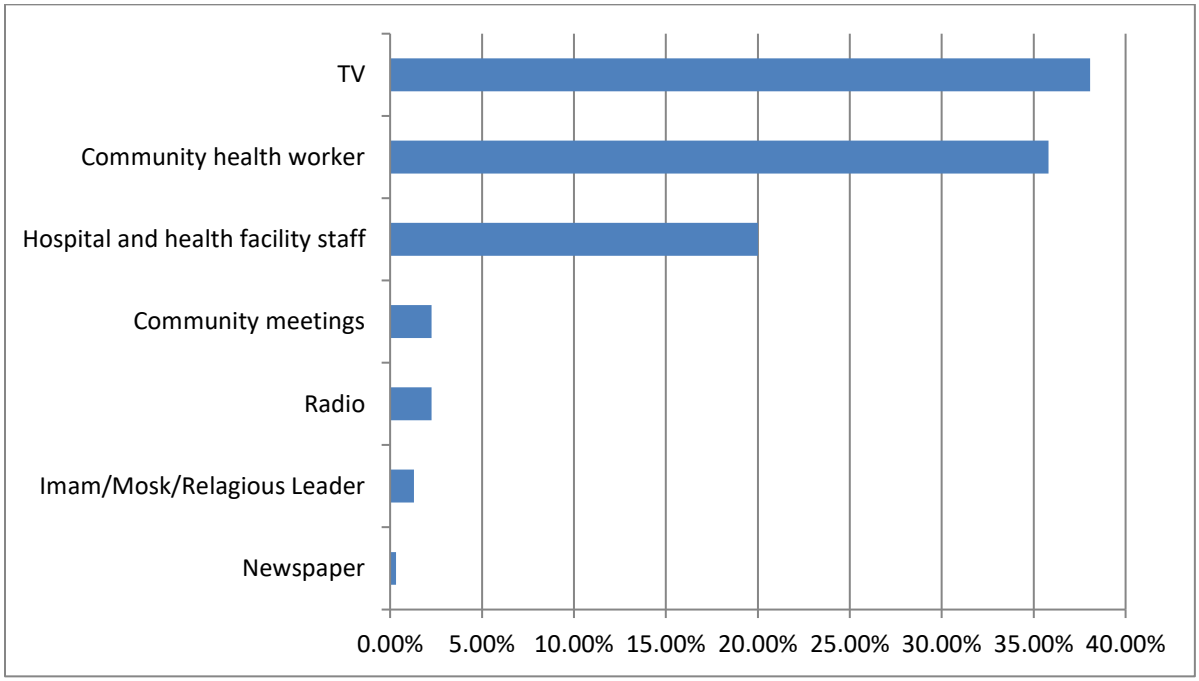
The source of health messages was explored by asking the respondents to recount from where they had heard or read maternal and child health messages. TV, health facility staff, CHWs and radio were the main source of information mentioned.

Figure 12: Current sources of information on MNCH



Just like existing sources of information, the preferred means registered almost a similar trend. It was however very evident that a higher number (40.3%) of women preferred TV on MNCH. Key informants identified community health workers, health facility staff and community meetings as the most trusted means of delivering MNCH messages.

Figure 13: Proffered sources of information on MNCH



DISCUSSION

The KAP survey has illuminated several knowledge, attitude and behavioral factors that underlie the prevailing maternal, newborn and child health situation in district two of Kabul city. Coupled with the widely known health systems weakness, these findings may to a great extent explain the remarkably poor access and utilization of maternal, newborn and child health services. This section undertakes to answer the research questions based on the findings of the survey.

There are clear disparities in the knowledge on importance of ANC visits among educated and non-educated. Women with secondary or university education were more likely to receive ANC services. But the level of education was not associated with completing all required four visits. It appears that educated women are better informed on maternal and child health issues as compared to non-educated women. This finding has been corroborated by key informants who stated that educated women are more knowledgeable on MNCH issues than non-educated.

Another instance of knowledge gap by women about mothers' health was the risks posed by early pregnancy. About 22.26 % of women disagreed whether early pregnancy posed risked to mothers and child health. Limited number of (6.63 %) of women reported not being aware that early pregnancy increases the risks of complications.

PERCEPTION ON HEALTH SYSTEM RESPONSE TO MNCH NEEDS

There were mixed attitudes towards the health system and its approach to MNCH needs. The positive side is that respondents saw health facilities as the first point of call for seeking advice and treatment when a pregnant woman had pregnancy-related complications or when a child was sick. 86.46 % of women said they would prefer to give birth in health facilities citing health workers adequately skilled and privacy as their reasons.

Majority respondents said they had received health messages from health workers and indeed health workers were one of the most trusted sources of MNCH information. These statistics paint a relatively good picture of community confidence in the health system.

On the flip side, there was notable lack of confidence in the health system as depicted by a considerable proportion (13 %) of respondents reported to give in home as as they don't trust health facility.

22.47% of respondents stated health facilities lacked adequate medicine and equipment to offer safe delivery. 10.86% of respondents believed that health facility staff didn't adequate skills for a safe delivery. Another significant barrier to access health facility was identified as unaffordable transport costs which reinforce the urgent need to open public health facilities to reduce the travel distances. Normally, health facilities should not be seen only as a source of privacy during deliveries but more as safe place due to presence of skilled health workers and adequate medicine and equipment.

PRACTICES WITH REGARD TO MNCH

There was a high prevalence of underage pregnancy with 43.44% reporting to have given birth to their first child below the age of 18. The mean age of first pregnancy was at the teenage stage with one reported at age of 11, 2 at age of 14 and 16 at age of 15 years old. This can be attributed to the lack of awareness by many mothers of the risks associated with underage pregnancies.

The place where a mother gives birth to her child makes a lasting impact on her and her child's health. Mother should be in position to select the right place for birth based on right information but the finding indicates that the final decision on where a woman will give birth was largely made by women's husbands or their in laws (35.76 and 35.96 % respectively during last child birth). This highlights the complex traditional and cultural issues that influence the mothers' health in the target community.

The survey highlighted a huge gap in family planning services knowledge and uptake. Considerable number of women reported having desired to delay pregnancy at some point (74%) and almost (26 %) of respondents did not report having had a desire for child spacing. This should be taken in light that respondents were the mothers, their desires plays a crucial role in their healthy life.

The uptake of family planning methods was extremely low with around33 % did not take any of birth spacing methods.

Long term modern family planning methods uptake was almost nonsexist. The survey recorded less than 5 % of participants knew about sterilization and implants. The reasons for not using the family planning methods ranged from unwillingness of husbands, considering children of gift of God and simply lack of information on birth spacing methods. These factors highlight the poor adoption of family planning methods was attributed by many respondents to women's rights, religion and/or culture and ignorance.

The completion of four required antenatal care services was low with varying reasons being given, ranging from being healthy through the entire pregnancy period to no reason at all. 38% of women actually reported ANC as not being necessary during pregnancy. Costs and distance were also reported impediments.

There is a clear incongruity between knowledge and attitude towards health facility delivery and the health outcome. While majority were aware of benefits of skilled birth attendance and indeed demonstrated positive attitude to health facilities but 56.615 reported to have experienced pregnancy complications, this may reflect on the quality of health services. Those who had experienced danger signs more than a quarter (36.19%) did not seek advice or treatment at health facilities instead went to pharmacies, religious leaders and TBAs. This provides an explanation why 32.85 % reported having had miscarriages, spontaneous abortion and child that died after birth.

MNCH-RELATED BEHAVIOR CHANGE COMMUNICATION

TV, community health workers and health facility staff, are the main sources of maternal and child health information. The KAP survey also found that community health workers followed by TV are the most trusted sources of health information. Community health workers and health facility staff also featured prominently. Communication in Afghan communities is largely oral which probably explains why print media was not very popular. This is also consistent with the fact that literacy levels are very low as demonstrated by the finding that a vast majority had not attended any formal schooling so oral messages are more favorable.

RECOMMENDATIONS

Based on the findings of the KAP survey and review of relevant literature, the following are the specific recommendations:

Recommendations' targeting communities' knowledge and practices on MNCH

1. Communities must be educated on critical benefits of family planning/ birth spacing. The programme should prioritize awareness on the various methods of birth spacing, especially long term methods. The strategies adopted must consider the cultural and religious sensitivities elicited by the issue of family planning.
2. Care International, MoPH and other health actors in concerned district should design and implement initiatives aimed at empowering men and women to take informed actions for optimum spacing of births to help reduce risks to the lives of women and children and improve the health and welfare of families. Given the cultural and religious barriers cited by a sizable proportion of respondents, child spacing promotion should bring on board religious and cultural opinion leaders. Successful promotion of child spacing from a religious perspective has been applied in similar settings.
3. All actors in urban Kabul should raise awareness of the harmful effects of certain practices that endanger maternal, newborn and child health including early marriages and pregnancy and pregnancy complication among others.
4. Awareness on importance of antenatal care need to be elaborated to all women of reproductive age and especially the need for early visit, within the first trimester, and ensuring the recommended four visits.

5. There is need for education on the various signs of danger in pregnancy and newborns. Men should also be sensitized on this and the urgent need to seek advice and treatment from health facilities as soon as possible
6. The importance of skilled attendance at birth need be a critical aspect in all MNCH campaigns targeting both men and women.Messages in this regard should be a priority so as to start addressing the high pregnancy and birth-related complications and mortalities.
7. There is need for a campaign against misconception surrounding early initiation of breast-feeding. The campaign should tackle the following misconceptions among others: Mother is unwell after delivery, colostrum milk is harmful to a newborn, and the breasts of newly delivered mothers have inadequate milk.
8. There is need to tackle the dropout rate in routine vaccination as evident from the findings and especially it is important to educate communities against the notion that vaccines are not safe to newborns or sick children should not be vaccinated.

Recommendations to improve the health system response to MNCHneeds

1. There is need to capitalize on the existing positive perception of health facilities by both men and women so as to further foster demand for MNCH services.
2. Health facilities as channels of delivering MNCH messages need to be enhanced given they were listed as the most trusted source and the fact that health professionals are more likely to disseminate correct and factual messages.
3. While the private sector plays an important role in any health system, the inherent dangers of over-the-counter drugs and self-medication especially during pregnancy and for a sick child need to be highlighted, both to policy makers and the consumers themselves.
4. More female community midwifes need to be trained to not only address the health worker shortage but also meet the preference by women for female providers of reproductive and maternal health services.
5. There is need to equip health facilities to deal with deliveries. Medical supplies and drugs need be made adequate so that health facilities do not become the impediment to skilled deliveries.

Recommendations touching on general health programming

1. Due to the behavioral and health systems barriers highlighted by the findings of this sur- vey, combination of both health facility-based and community-based approaches will be required to increase MNCH serves uptake.

Recommendations on proper and effective channels of information on MNCH

1. Behaviour change communication initiatives in the project area should use a mix of channels with more focus on oral means of communication especially counselling and interpersonal communication by health workers (both formal and CHWs). Given the high diffusion rate of information (from person to person) influential opinion shapers should be identified and engaged as agents of behaviour change.

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ANNEX-1

SURVEY INSTRUMENT

Name of Guzar:	
District:	
Name of interviewer:	
Date of interview:	
Questionnaire checked by:	
Date of cross-check:	

Instructions to the interviewer:

1. Circle the answers under the coding category column
2. Take note of additional instructions in ***bold italics*** against some questions

INTERVIEW WITH WOMEN OF CHILD BEARING AGE (15-49 YEARS)

No.	QUESTIONS AND FILTERS	CODING CATEGORY

C1	Age of the respondent in completed years	---------- years
C2	What highest level of school have you attended?	Never attended school ----------1 Pre-primary /Nursery----------2 Primary, not completed----------3 Primary, completed----------4 Secondary, not completed----------5 Secondary, completed----------6 College/University----------7 Vocational/ adult education----------8 Other (specify)---------- 99
C3	Have you ever been pregnant (including now)?	Yes----------1 No----------2 ***(Skip to C8)***
C4	At what age (in years) did you have your first child?	----------years Carrying first pregnancy----------00
C5	How many children have you given births to that are still alive?	----------
C6	How many children have you given births to that have died after birth?	----------
C7	Have you ever had a pregnancy that miscarried, was aborted, or ended in a stillbirth?	Yes----------1 No----------2
C8	At what age do you think a woman should have their first baby?	---------- years

C9	Early pregnancy (under age of 18) increases the risk of complications and can lead to death of mother and her child; do you agree, disagree or don't know?	Agree----------1 Disagree----------2 Don't know----------3

C10	In your knowledge, could you mention the methods that can be used to delay pregnancy and for healthy birth spacing?	Sterilization (vasectomy/ tubal ligation)----------1 Implant ----------2 Intra-uterine contraceptive device (IUD)----------3 Injection ----------4 Pills----------5 Condom ----------6 Cycle beads/ safe days----------7 Coitus interuptus ----------8 Breastfeeding----------9 Abstinence---------- 10 Other (specify)----------99 I don't know---------- 00
C11	In this community, where can one get modern birth spacing methods?	Health facility----------1 NGO/CBO----------2 Pharmacy/ medicine shop----------3 TBA/ CHWs----------4 Other (specify)----------99 I don't know---------- 00

C12	Have you at any time, wished to delay pregnancy or space your births?	Yes----------1 ***(go to C13)*** No----------2 ***(Skip to C16)***
C13	When you wished to space the birth of your children did you use any birth spacing methods?	Yes----------1 (Go to C14) No----------2 (Go to C15)

C14	Which method did you or your husband use?	Sterilization (vasectomy/ tubal ligation)---------1 Implant ----------2 Intra-uterine contraceptive device (IUD)----------3 Injection ----------4 Pills----------5 Condom ----------6 Cycle beads/ safe days----------7 Coitus interuptus ----------8 Breastfeeding----------9 Abstinence---------- 10 Other (specify)----------11 I don't know---------- 0
C15	Why didn't you use any birth spacing method?	I don't know of any birth spacing method--------1 I don't know where to get from----------2 My preferred method was not available--3 Could not afford the cost----------4 Distance to the place where i can find method---5

		Not allowed by our culture----------6 Not allowed by my religion----------7 Not allowed by my husband……8 Not allowed by my in laws……..9 Fear of side effects----------10 Other (specify)----------11 I don't know---------- 12

C16	What would you say is the reason why you haven't wished to space the birth of your children?	Children are given by God----------1 I have no control over when children will come---------2 I don't know any method of child spacing---------3 Fear of side effects from the methods----------4 Prohibited by our religion----------5 Prohibited by our culture----------6 I can afford to bring up many children---7 My wife is unwilling ----------8 Other (specify)---------- 9 I don't know---------- 00

C17	Did you go for health checkups (antenatal care) during the last pregnancy?	Yes----------1 ***(go to C19)*** No----------2 ***(go to C18)***
C18	What made you not to seek antenatal care? ***Multiple responses possible. Probe: what else?***	Not important in pregnancy----------1 Lack of transport----------2 Long distance----------3 High cost of care----------4 I was okay all through----------5 No reason----------6 Other (specify)----------99
C19	At what gestational age did you first go for the antenatal checkup during the last pregnancy? ***If the respondent has difficulty remembering exact month, you can assist by readingthe choices "was it…."***	Within the first 3 months----------1 Between 3 and 6 months----------2 Within the last 3 months----------3 I don't know.....00
C20	How many times did you go for antenatal care during your last pregnancy?	---------- times

C21	The last time you went for antenatal care, who examined you? ***Probe: Was it a man or a woman?***	Male----------1 Female----------2
C22	During the last pregnancy, did you know the date that the baby was expected to arrive?	Yes ----------1 No----------2
C23	During the last pregnancy, did you plan where you would deliver the baby?	Yes----------1 No----------2

C24	Where did you plan to deliver the baby?	Health facility----------1 ***(go to C25)*** Home----------2 ***(go to C26)*** Other (specify)----------99
C25	***(For those saying health facility in question C25)*** For what reasons did you prefer to deliver in health facility?	Safer to deliver there ----------1 Skilled care from health workers---------2 Health facility is near----------3 Recommended by relative----------4 Other (specify)----------99
C26	***(For those saying home in question C25)*** For what reasons did you prefer to deliver at home?	No fees charged/ cheaper----------1 High transport costs ----------2 Do not trust/like health facility----------3 Better care at home----------4 To attend to my other children----------5 Recommended by relative----------6 Other (specify)----------99

C27 What do you think about the following statements regarding giving birth at a health facility ***(probe if they agree, disagree or do not know)***

Question	Agree	Disagree	I don't know
The health workers at the health facility are adequately skilled			
The health facility has all the medicines and equipment to make delivery safe			
The health facility has adequate privacy			

	There is no problem even if the health worker assisting the delivery is a male.			

C28	When you were pregnant with your last child, who made the final decision on where you would give birth?	Myself----------1 My husband----------2 My mother/mother in law----------3 Other relative----------4 Other (specify)----------99
C29	During the last pregnancy, did you have ready transport arrangements in case labor began or in case a complication developed?	Yes----------1 No----------2
C30	What are the symptoms during pregnancy that would indicate that there is something going wrong with the pregnancy? ***Multiple responses possible. Do not read the choices; let the respondent mention based on their knowledge. Encourage more answers by probing: What else?***	Vaginal bleeding----------1 Pelvic or abdominal pain----------2 Persistent back pain----------3 Gush of fluid from vagina----------4 Swelling of the hands/face----------5 Severe headaches/ blurred vision---------6 Preterm regular contractions----------7 No fetal movement----------8 Other (specify)---------- 9 I don't know---------- 00
C31	Did you experience any of these signs during your last pregnancy?	Yes----------1 ***(go to C32a)*** No----------2 ***(go to C32b)***

C32a C32b	What action did you take when you experienced these signs? What action should a woman take if she experiences these signs? ***Circle all mentioned***	Seek advice/treatment from health facility----------1 Seek advice/treatment from TBA--2 Purchase medicine from pharmacy/shop----------3 Seek prayers from religious leader------4 Take rest----------5 Nothing/ wait for problem to heal--------6 Other (specify)----------8 I don't know---------- 9
C33	After noticing these signs, how long should a woman take **(did you take)** before seeking care?	Less than 12 hours ----------1 12-24 hours----------2 Over 24 hours----------3 Other (specify)----------99 I don't know---------- 00
C34	After how long did you breastfeed your baby when you gave birth?	Within 1 hour----------1 (***skip to C36***) Within 12 hours----------2 After 12 hours----------3
C35	Why was the baby not put on breast within 1 hour?	Mother was unwell----------1 Taboo----------2 Breast not producing milk----------3 Colostrum's not good for baby----------4 Other (specify)----------99 I don't know---------- 00

C36	At what age did you start giving your child other drinks/food apart from your breast milk?	----------age in months If less than one month----------00

C37	What signs/symptoms would indicate that a newborn is sick and in danger?	Lethargy/extreme weakness----------1 Poor suckling----------2 Skin color change----------3 Vomiting----------4 Diarrhea/ dehydration ----------5 Difficult/ rapid breathing----------6 ----------7 Other (specify)----------99 I don't know---------- 00

C38	In the last 3 months, have you heard or read about health of mothers and children?	Yes----------1 No ----------2

C39	What messages about mother and child's health do you still remember? ***<u>Probe: what else?</u>***	Hygiene messages----------1 Immunization----------2 Antenatal care----------3 Disease specific messages----------4 Other (specify)----------5 1 ---------- 2 ---------- 3 ----------

C40	From what sources did you hear or read about this? ***Multiple responses possible. Probe: What other source?***	Radio----------1 TV ----------2 Newspaper----------3 Internet----------4 Billboard/ posters/wall chart----------5 Hospital / health center staff----------6 Community health worker----------7 Imam/mosque/ religious leader----------8 NGO/CBO/ women group----------9 Community meeting----------10 Husband/ relatives----------11 Others (specify): ----------99
C41	What source of information on mother and child's health do you (or would you) trust **most**? ***Only one response***	Radio----------1 TV ----------2 Newspaper----------3 Internet----------4 Billboard/ posters/wall chart----------5 Hospital / health center staff----------6 Community health worker----------7 Imam/mosque/ religious leader----------8 NGO/CBO/ women group----------9 Community meeting----------10 Husband/ relatives----------11 Others (specify): ----------99

C42	Does your last born child have a vaccination card?	Yes----------1 ***(go to C43)*** No----------2 ***(go to C44)***
C43	If yes, check the card and tick all the immunizations that have been given.	

Vaccine	**Yes**	**No**
BCG		
OPV 1		
OPV 2		
OPV 3		
DPT1/PENTAVA-LENT1		
DPT2/PENTAVA-LENT2		
DPT3/PENTAVA-LENT3		
Measles		

C44	If card is not available ask the mother the following questions:

Questions	Yes	No
Has the child ever been given an injection in the arm that left a scar?		
Has the child ever been given immunization drops to prevent him/her from getting disease?		
If YES, how many times had he/she been given the drops?	_____	
Has the child been given an injection in the thigh to prevent him/her from getting disease?		
If YES, how many times had he/she been given the injection?	_____	
Has the child ever been given an injection in the upper right arm at the age of 9 months or older, to prevent him/her from getting disease?		
If YES, how many times has he/she been given the injection?	_____	

C45	***If the card indicates some vaccination were not given or if any of the answers to questions above is NO ask the mother the following question.*** I see your child is not fully immunized. Can you tell me why?	Lack of information Unaware of need for immunization-------1 Unaware of need for completing all doses ----------2 Not aware of place or time of immunization----------3 Fear of side effects----------4 Obstacles: Health facility too far----------5 Time of immunization inconvenient--------6 Vaccinator absent----------7 Vaccine not available----------8 Mother too busy/sick----------9 Child ill----------10 Long waiting time on the queue----------11 Unpleasant treatment by health worker----12 Other (specify)----------13 I don't know---------- 00

ANNEX-2 FOCUS GROUP DISCUSSION GUIDE

CONSENT

Good morning/afternoon, my name is ... …. and I am working for Save the Children. Currently we are conducting a survey on mother and child health in your community. The information will be useful for us, the government and other agencies in planning and delivery of health services

I want to start by thanking you for agreeing to participate. We are very interested to hear your valuable opinion on the health of mothers and children in this community.

I also wish to assure you that the information you give us is completely confidential, and we will not associate your name with anything you say in the focus group. You may refuse to answer any question or withdraw from the study at any time. However, we hope you can participate fully since your opinion and information are very important.

The group discussion will take approximately one hour and I wish to kindly ask all of you to actively participate in the debate.

Do you have any questions before we begin? Can I now open the discussion?

SITTING ARRANGEMENT

Indicate in the box below the position for sitting arrangement

{Moderator (MD), note-taker (NT), audio-tape

(AT) and individual respondents (by their ID)}

QUESTIONS

1. What is the general understanding, practice and uptake of MNCH services in this district?
   a. Are the communities knowledgeable on the requirements during pregnancy? What is the knowledge on:
   - Maternal nutrition?
   - Antenatal care?
   - Skilled deliveries?
   - Family planning?

   b. Are the communities knowledgeable on child health? What is the knowledge on:
   - IMCI
   - Vaccination against preventable diseases
   - Nutritional requirements for children

   c. What are the gender differences in knowledge of the MNCH services offered in this community?
2. What are the MNCH services are being provided in the health facilities in district region?
   a. Are the MNCH services offered by the health facilities adequate? What are lacking?
3. What are the factors influencing the provision of MNCH services in this district region?
   a. What cultural beliefs influence the MNCH?
   b. What are the driving factors influencing places of child birth in this community?
   c. What are the socio-economic factors influencing the provision of MCH services in this region?

4. What BCC strategies/channels on how to reduce maternal and child morbidity have being implemented in the region?
    a. Who are the priority target audiences for the BCC and interventions for MNCH activities?
    b. What are the specific activities and IEC materials for the above target audiences have been planned and actually rolled-out?
    c. What channels have been used for the above activities?
5. What are the key barriers to successful acquisition of positive healthy behaviour among the different target groups
6. What are the three most important behaviour change communication needs?
7. What are the preferred communication channels for MNCH appropriate for maximum impact in this region?
    a. What are the appropriate materials for communication?
    b. Who are the trusted persons to communicate the desired messages?
8. What are your final thoughts and recommendations concerning the MNCH?