Understanding how to increase uptake of WASH, nutrition and maternal and child health services in Afghanistan

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ABBREVIATIONS

ANC	Antenatal Care
CHP	Community Health Promoter
CHW	Community Health Worker
DAWAM	Driving Action for Well Being to Avert Mortality
DFA	De facto Authorities
EPI	Essential Programme on Immunisation
FGD	Focus Group Discussion
IDI	In-depth Interview
MCH	Maternal and Child Health
MUAC	Mid Upper Arm Circumference
NGO	Non-Government Organisation
PLW	Pregnant and lactating women
PNC	Postnatal Care
PWD	People with Disabilities
RUTF	Ready-to-Use Therapeutic Food
RUSF	Ready-to-Use Supplementary Food
WASH	Water, Sanitation and Hygiene

1 EXECUTIVE SUMMARY

This report summarises qualitative research with mothers, families, and key influencers in Afghanistan to understand their access to information, knowledge, attitudes and practices on WASH, nutrition and maternal and child health. The aim of this research is to identify Afghans' information needs, the barriers and enablers to accessing services and adopting practices, and the issues for communication to address.

The data was collected between December 2023 and February 2024 through 13 focus-group discussions (FGDs) with pregnant and lactating women (PLW), and 30 in-depth interviews (IDIs) with husbands and mothers-in-law, in seven provinces – Nangarhar, Ghor, Daikundi, Faryab, Badghis, Herat and Badakhshan.

Research participants demonstrate a limited understanding of when and how to treat water to make it safe to drink, and limited knowledge of sanitary methods of disposing of household waste and rubbish. While respondents have first-hand experience of the various illnesses caused by drinking unsafe water and unsanitary practices, they lack awareness of other options or solutions. Furthermore, good handwashing and menstrual hygiene practices are hindered by the limited availability of facilities and materials (such as soap).

Findings show that knowledge around ideal nutrition for newborns, children under five and pregnant and lactating women is prone to distortion by traditional beliefs, leading to some potentially harmful practices, such as giving newborn babies animal fat alongside colostrum, and supplementing breastmilk with herbal medicines. And while respondents can list nutritious foods that mothers and children under five should consume, in practice it is budget, rather than need, that dictates the type of food that is available to the household.

Among target audiences, knowledge and understanding of key maternal and child health services, including ANC and PNC check-ups, remains limited and generic, and highly influenced by the traditional beliefs and experiences of elder women, especially mothers-in-law. Furthermore, findings indicate that knowledge of recommended MCH practices often does not translate into real-life practice. While respondents are aware of the benefits of institutional delivery, those living in remote rural areas often choose to give birth at home, partly because of accessibility issues, but also because of prevalent attitudes and social norms.

Many of the perceived barriers to people accessing and availing WASH, nutrition and MCH services are largely consistent. Key informants and participants report that the overarching barriers are the lack of access to clinics, hospitals and services; financial constraints; lack of knowledge and awareness; unhelpful social norms and traditional practices; and a lack of availability of essential medicines and hygiene materials.

Furthermore, findings show that the current operating environment for humanitarian organisations in Afghanistan is particularly challenging due to the imposition of restrictive policies under the de facto authorities (DFA), such as those preventing women from travelling alone and practical barriers to the delivery of services, and the associated decline in donor funding available for the public health sector. As such, access to WASH, nutrition and MCH services and support, particularly for those living in remote, rural areas of Afghanistan underserved by the public health system, is increasingly challenged.

Aside from the removal of practical barriers, such as accessibility to, and availability of services, research participants cite knowledge and awareness-raising in communities, and particularly among key influencers such as husbands and mothers-in-law, as a key enabler of positive WASH, nutrition and MCH practices and uptake of services.

2 PROJECT BACKGROUND

After decades of instability, exacerbated by severe drought and natural disasters, Afghanistan is facing a prolonged humanitarian crisis, with millions of people living with poor or no access to health care or food. According to UN OCHA's November 2021 report, just 393 out of 2,312 health facilities in Afghanistan were fully functional.[1] Worsening the situation, since August 2021, financial and technical support for Afghanistan's public health system has been sharply reduced, with the World Bank and other donor countries and institutions cutting development funding. According to research conducted by Human Rights Watch, humanitarian aid organisations, which have tried to fill the gaps in public health funding, have had to close clinics due to lack of funds, and local aid groups face barriers in importing supplies, reporting shortages in medicines and equipment throughout the country.[2]

This reduction in international support and funding comes at a time when Afghanistan is facing the compounding impacts of drought, political change, and economic collapse. In 2023, two thirds of Afghanistan's population needed urgent humanitarian assistance to survive.[3] In particular, infants, young children and their mothers are most vulnerable to malnutrition, due to food insecurity, poor feeding practices, cultural and gender norms, and high morbidity due to reduced access to WASH and health services. Women reported eating less food than other household members because insufficient food for the household led them

1 United Nations Office for the Coordination of Humanitarian Affairs (OCHA) (2021) *Afghanistan Health Facilities and Functionalities* [online]. Available from: https://data.humdata.org/dataset/afghanistan-health-facilities [Accessed 23 May 2024].

2 Human Rights Watch (2024) *"A disaster for the foreseeable future" – Afghanistan's Healthcare Crisis* [online]. Available from: https://www.hrw.org/report/2024/02/12/disaster-foreseeable-future/afghanistans-healthcare-crisis [Accessed 23 May 2024].

3 Limaye, Y. (May 2023) *Afghanistan: 'Nothing we can do but watch babies die'* [online]. Available from: https://www.bbc.co.uk/news/world-asia-65449259 [Accessed 23 May 2024].

to prioritise feeding their children and male relatives rather than themselves. Unmet maternal and child health needs and malnutrition continue to cause substantial mortality and morbidity. Multiple parallel shocks are driving Afghanistan's health needs and are severely impacting the increasingly strained health systems and services. Infectious diseases like Acute Watery Diarrhoea (AWD) and cholera are the consequence and catalyst of poor humanitarian conditions, including poor sanitation, water quality and quantity, malnutrition, reduced school attendance, poor health, and reduced income. Seventy-nine per cent of households in Afghanistan do not have enough water for drinking, cooking, bathing, and washing, indicating high water needs across Afghanistan's provinces.

Relief Web's Afghanistan Health Cluster Bulletin from September 2023 indicated that access to emergency reproductive, maternal, newborn and child health (RMCH) services remains limited for a significant portion of the population due to the limited capacity of providers and a weak referral system. It also detailed that Afghanistan's population is exposed to traumatic events and psychological problems, with one in two Afghans suffering from psychological distress and one in five facing role impairment due to mental health issues.[4]

People affected by crises continue to face challenges to access information on humanitarian assistance and other life-saving information to make informed decisions for them and their family. Marginalised groups including women, girls, older people, and people with disability are affected and excluded more severely due in large part to imposed restrictions and other barriers that prevent them from obtaining timely information and assistance.

In response to this situation, the Driving Action for Well Being to Avert Mortality (DAWAM) project aims to contribute to decreased morbidity and mortality in women and girls and high-risk groups including persons living with disability in Afghanistan. The project is funded by the Foreign, Commonwealth & Development Office (FCDO). It is implemented in seven provinces by a consortium consisting of World Vision (WV), Action Aid, Action Against Hunger (ACF), Afghanistan Women's Education Centre (AWEC), Agency for Assistance and Development of Afghanistan (AADA), BBC Media Action, and Nai Qala.

4 ReliefWeb (2023) *Afghanistan Health Cluster Bulletin, March & September 2023* [online]. Available from: https://reliefweb.int/report/afghanistan/afghanistan-health-cluster-bulletin-march-2023 and https://reliefweb.int/report/afghanistan/afghanistan-health-cluster-bulletin-september-2023 [Accessed 23 May 2024].

RESEARCH

This formative research was designed to inform the DAWAM project on integrated programming on the WASH, nutrition, and maternal and child health (MCH) component of FCDO Afghanistan's Food Security and Livelihoods Programme. The study sought to identify current levels of knowledge, access to information, priority gaps and information needs on WASH, nutrition, and maternal and child health topics for mothers, families, and key influencers in Afghanistan. The research aimed to unpack enablers behind positive attitudes and practices around these key areas, as well as barriers that need to be addressed.

3.1 Research design

This formative research employed qualitative research methodologies, including Key Informant Interviews (KIIs) with World Vision and implementation partners, as well as Focus Group Discussions (FGDs) and In-depth Interviews (IDIs) with target populations.

A total of nine KIIs with consortium and local partners, relevant cluster leads, plus selected partners in each of the locations were undertaken to provide a broad perspective on the WASH, nutrition, and maternal and child health programmes currently implemented in the focus provinces. These interviews were focused on gaining an understanding of the implementation of the intervention, the risks and challenges of implementation, and possible alternative ways to mitigate those challenges.

Thirty IDIs and 13 FGDs with community members in the target population (including men and women across different age groups, and pregnant and lactating women (PLWs) aimed to understand audiences' knowledge, behaviours, drivers of behaviour, barriers to safe behaviours, and audience priorities regarding basic WASH, nutrition and maternal and child health services. The sample included five people with disabilities (PWD).

The field research was conducted between December 2023 and February 2024. The interviews were conducted in local Dari and Pashto languages by experienced female and male data collectors, transcribed, and analysed using the framework analysis approach.

The geographic focus of the research included DAWAM project target provinces – Nangarhar, Ghor, Daikundi, Faryab, Badghis, Herat and Badakhshan.

4 RESEARCH FINDINGS

This section details findings based on interviews and focus group discussions conducted with target audiences (pregnant and lactating women, mothers-in-law, and husbands) and key informants (consortium and local partners, relevant cluster leads, and partners). The research explores the issues target audiences face related to water, sanitation, and hygiene (WASH), nutrition, and maternal child health; their level of awareness and existing knowledge about these key health areas; and the barriers and challenges they face in taking up available WASH, nutrition, and maternal and child health services. Findings detailed below reflect the perspectives of both the target audiences and key informants.

4.1 WASH

4.1.1 Available Services

According to key informants, provision of WASH support to communities includes initiatives to enable access to safe water supply, including the construction of wells, rehabilitation of old wells, pipe scheme extensions, restoration of springs, hand pumps, reverse osmosis systems, as well as solar powered latrine and water supply systems. They also distribute hygiene kits in villages, schools, and health clinics. One organisation also reports implementing an emergency response strategy, involving the transfer of water into tankers to distribute a daily quota of seven litres of water per person in times of emergencies.

Support also focuses on raising awareness of positive WASH practices in communities, with information provision and capacity-building of various key stakeholders. This involves awareness sessions to provide information on cleanliness maintenance, handwashing practices, community toilet services, and addressing sensitive topics such as menstrual hygiene, women's rights, and the prevention of early marriage for girls. Awareness sessions are conducted in public spaces including clinics, mosques, and schools, as well as in homes, with support from local community health promoters (CHPs), who play a pivotal role in

coordinating community-based sessions. Furthermore, training sessions are undertaken to build the capacity of community health workers, WASH staff, and religious leaders, who act as key influencers in communities. Organisations distribute Information, Education, and Communication (IEC) materials through brochures, photos, posters, and projectors where feasible.

"We provide the sessions on WASH with the help of Community Health Promoters at mosques, homes and public places. The Community Health Promoters include male and female staff, and they are in close contact with community influencers and coordinate sessions for WASH teams in the communities. To convey information, the WASH teams use posters, banners, and leaflets during the sessions."

WASH expert, World Vision International, Kabul

However, key informants highlight significant and increasing challenges faced by practitioners in delivering WASH programmes across the country. They note that under the DFA, the imposition of restrictive policies and strategies by the Ministry of Public Health has severely hindered their work. These policies include restrictions on their movement between villages and increased bureaucratic and practical barriers to the set-up and delivery of projects, particularly where organisations do not have a physical office located in Afghanistan.

According to key informants many donors and organisations previously working in Afghanistan have halted activities or withdrawn because of these restrictive policies and barriers to programme implementation. Furthermore, engagement with stakeholders poses challenges to new projects being established, particularly the prolonged process of establishing Memorandums of Understanding (MOUs) with de facto authorities. Key informants note that the registration process currently takes approximately three months, resulting in significant project delays. Attempts to address this through cost extensions for short-term projects face resistance from donors, creating a significant hurdle in project implementation.

With restrictive new rules imposed on women in Afghanistan, female staff members have faced significant limitations in their ability to work, reducing the potential for consortium partners and other organisations to reach and engage women with critical information and support, particularly in remote areas. Furthermore, these restrictions mean training of female staff has been curtailed, which will lead to gaps in appropriately qualified female health care workers in the future.

4.1.2 Access to Services

Key informants in the WASH sector note that there is a lack of WASH services support available to communities, particularly those in remote, rural areas. This perception of a lack of WASH services is reflected among participants. The unmet need in these communities mean they continue to face significant challenges to accessing water, especially clean, safe drinking water, and are at increased risk of malnutrition and disease. According to key informants, people collect water from canals and open sources, which are often at great distance from their homes. They also cite a lack of essential hygiene materials available to communities, meaning that essential sanitary products including soap, toothpaste, toothbrushes, towels, combs, and nail cutters are scarce.

4.1.3 Knowledge

Knowledge of Safe Drinking Water

According to practitioners, there is a lack of knowledge among communities about safe drinking water. They note that people cannot differentiate between safe and unsafe water sources and have limited knowledge of how to treat unclean water to make it safe to drink. This observation was reflected among target audiences, who demonstrate a limited understanding of how to identify clean water. 'Flowing' water collected from a spring was considered clean, whilst run-off water, water without salt, and water without visible stones or sand, was also deemed clean. Participants living in urban areas with access to piped water note that pipeline water had undergone treatment and is therefore safe to drink. Participants report using taste and smell to define whether water is clean enough to drink. Conversely, water collected from unprotected wells, rivers,

and canals which visibly contained dirt and debris is deemed 'unclean'.

"We know it is hygienic when the water is flowing and clean."

Husband, Badghis province

Participants also demonstrate limited knowledge of when and how to treat water to make it safe to drink. For example, respondents mention that they only treat water if it looks dirty, and do not tend to treat water collected from wells, springs and *karizes*, as they perceive this water to be clean. The main method of treatment mentioned by participants is boiling water. However, respondents lacked clarity on how long water should be boiled to make it safe to drink. Participants also note that the cost of fuel to boil water is a barrier to utilising this method. Other methods of treating water mentioned by respondents include using a cloth to filter dirt, use of chlorine powder, and using salt or chlorine to disinfect well water, falsely believing the water to be safe when it looks cleaner.

"We take a fine mesh with us and place it over the container. While drawing water from the well we use the mesh to filter out dust and other debris, preventing them from going inside. Then we bring the water home for drinking. Yes, the water is not clean, which is why the dust and other particles stay on the mesh, and only the water goes inside the container, ensuring a cleaner supply when we take it home."

Pregnant woman, Nangarhar province

Findings indicate that participants are aware of some of the health impacts of drinking unclean water, although they demonstrate only limited understanding of the full extent of the consequences of water-borne diseases. Participants report that drinking unclean water could cause diarrhoea, cholera, sore throat, infection, kidney stones, and stomach and lung disease. They also note that children are particularly vulnerable to health issues related to drinking unsafe water because of their weak immune systems, and that they commonly suffer from diarrhoea, flu, and fever as a result.

"So, the problems are for everyone. Kids have chest problems, and they get sick more often. We also get sick. The winter is without any rainfall, and it is a drought."

Pregnant woman, Nangarhar province

Participants report receiving some information about access to clean water and water treatment methods in community engagement sessions run by NGO staff and via local health staff when they visit clinics. Others mention learning information via radio and television.

"On TV, some people were saying that clean water is like this. In the past, there was no pipeline, and all the people were using river water. Ever since these organisations have started working, people have become wiser. This, through TV and whatever they watch, has led them to separate their drinking water from the water used for other purposes."

Mother-in-law, Badakhshan province

Knowledge of Sanitation

Participants demonstrate awareness of the negative consequences of poor sanitation. They understand that practices such as open defecation and improper disposal of excreta and household waste, lead to the spread of diseases such as cholera, dysentery, diarrhoea, and gastrointestinal diseases, and are aware of the benefits of using a latrine. However, practical knowledge of proper sanitation methods is somewhat limited among participants.

Participants report having access to a latrine in their household and identified several features of a 'safe' latrine. These include a flush, septic tank, water, ventilation, a door, soap, and a handwashing area. They also mention digging deep holes far from wells and water sources to avoid risk of contamination and the importance of maintaining a level of cleanliness in the latrine by washing it with water and antiseptic, if possible.

"If I say that the safest toilets are the ones which have a door, ventilation, septic tank, and those with water are the best ones."

Husband, Faryab province

Respondents report limited knowledge around safe and sanitary disposal of household waste, reporting that they have not received much information about rubbish disposal. Participants had taken advice about disposal of waste from friends and relatives, as well as NGO staff, with one example given of NGO workers previously advising the community on safe disposal of household waste.

"Women used to come and ask where we throw the trash and advised us to put soil on it. To the best of our understanding, the women were from an organisation, and we were instructed to dig the earth and refill the hole with soil."

Pregnant woman, Nangarhar province

Knowledge of Handwashing

Participants demonstrate awareness of the need to wash hands at key points, including before and after eating, after using the latrine, before breastfeeding, after touching animals, and before and after cooking. In addition, participants also mentioned the need to wash hands after waking up in the morning, and throughout the day as they completed household chores.

"Before and after going to the toilet, and after touching the chickens, we have to wash our hands."

Mother-in-law, Ghor province

However, there is limited awareness of rules for effective handwashing. Participants explain that hands must be washed and rubbed well with soap or handwashing liquid but demonstrated limited knowledge of the time required for handwashing, cleaning nails, and drying hands. When queried, they offered a range of views on the appropriate duration of handwashing – ranging from 20 seconds to three minutes.

Participants demonstrated awareness of the benefits of proper handwashing with soap or handwashing liquid, citing that it can help prevent the spread of microbes and help avoid diarrhoea, cholera, typhoid, and stomach diseases.

"The benefit of washing hands is that it saves you from diseases. People say that children get diarrhoea while teething, but...it is actually that the child is touching the ground and taking that hand and putting it into

his or her mouth without washing it. The dirty hand, after being in contact with the surface, is causing the germs to enter his or her body and make the child sick."

Mother-in-law (PWD), Nangarhar province

Participants note that they learned about good hygiene practice from social media, television, radio, friends and family (particularly those from urban areas), at health clinics, and from doctors. They report that the information they received was helpful and supported them to improve their handwashing practices and overall cleanliness.

Knowledge of Menstrual Hygiene

Knowledge of menstrual hygiene among female research participants is varied. They report good understanding of some of the practical aspects of maintaining good menstrual hygiene. However, myths and misconceptions around menstruation itself is common, particularly among older women and mothers-in-law. Whilst participants are aware that girls first menstruate between the ages of 12 and 18, there is some belief that certain factors influence the age of menstruation. For example, participants mention that 'stronger' girls, girls who have more protein in their diet (i.e. the daughters of butchers and doctors) and girls who have a 'comfortable' childhood, will menstruate at a younger age. Other common myths around menstruation cited as fact by participants include avoiding drinking cold or carbonated drinks, consuming sour or bitter foods, sitting on cold ground, and avoiding exercise during menstruation.

"From a dietary perspective, it's important to consume warm foods while avoiding pickles, carbonated beverages, and sour foods."

Lactating woman, Herat province

Participants demonstrate awareness that maintaining menstrual hygiene helped to prevent health issues, such as urinary tract infections. They report that during menstruation, women should use clean cloths and change them regularly – every hour or three times daily, depending on the amount of bleeding experienced. They cite the importance of washing menstrual cloths using soap and clean warm water, and ensuring they are adequately dried and stored.

"Wash it with soap and water, then put it under the sunlight and keep it between the clothes."

Mother-in-law, Badghis province

Knowledge of menstruation and menstrual hygiene is mostly learned by sharing between women, mostly family members and friends. Older women who were interviewed mentioned that girls can feel shy about discussing menstruation with them, and that they prefer to discuss with other girls. Participants also report receiving information from media outlets and NGOs via at-home information sharing sessions, while others report getting information from teachers, doctors, and through studying books.

"Due to feeling ashamed, I wasn't able to tell anyone, so I washed the cloth very well on my own."

Pregnant woman, Herat province

4.1.4 Practices

Practices Related to Drinking Water

Participants report accessing water from several sources such as rivers, canals, *kariz* (aqueducts), springs, private and public wells (with and without solar power), piped water, and urban piped water sources for both drinking and washing. The most common water sources accessible to participants are spring water and well water, as they are available in rural areas. Participants note that some provinces do not have protected water sources such as springs and *karizes*, and where these are available, they are located at distances ranging from approximately 250 meters to 10 kilometres from households. As a result, water collection can take several hours.

"We are utilising water from the spring, which naturally emerges due to our location being in a mountain-locked area. Since there isn't an existing water supply network established by any entity, we resort to using canal water… which is a flowing water source. There is no assurance of one hundred percent safety in the water available for our usage."

Husband, Badakhshan province

Participants mention that they use the water from the same water sources (such as wells, springs or *karizes*) for drinking, washing and even for agriculture. In certain areas, especially in Faryab province, people rely on separate sources for drinking and washing due to the presence of salt in the water. Participants note that due to financial constraints they cannot afford to buy bottled water for drinking. People mention collecting between 10 and 20 water containers per day, totalling around 100-200 litres of water, which are generally carried home, or transported via wheelbarrows, motorcycles, or on donkeys. Notably, participants report women and girls are primarily responsible for collecting water, while fathers and elder brothers will often collect water at night, if needed.

Participants report storing water for drinking in separate containers, such as water coolers and protected containers, whilst water for washing is stored in unprotected containers and buckets.

"The stored water is usually used for important tasks such as washing clothes and dishes. We make an effort to bring fresh water for drinking, while the stored water is utilised for other household purposes, including bathing."

Husband, Ghor province

Practices Related to Sanitation

Key informants highlight the common practice of open defecation, often ingrained in local habits, as hindering the adoption of latrine usage. Reflecting this, participants note that whilst many households in their communities now have a latrine available, a lack of public latrines means that open defecation is the only option for those attending to work or visiting markets (particularly men who are out of the home for long periods of time). Furthermore, respondents note that when it is dark and cold, access to a latrine can be limited, particularly for women and children, elderly, and those with disabilities, who choose open defecation rather than navigating the distance to a latrine.

"We are encountering these problems frequently due to the absence of public toilets. Consequently, many individuals resort to open defecation in areas like markets or other open

spaces. While most people have private toilets in their homes, the lack of public facilities leads to widespread open defecation."

Husband, Faryab province

According to participants, household latrines are typically built by the families themselves, without any external expertise and using limited materials. Decisions around the design of the structure, materials to use, and where to locate the latrine, are made by the men of the household, and limited by financial constraints and only basic knowledge of good sanitary standards. While descriptions of available household latrines varied, they were generally described as very basic, with pits rather than septic tanks, mud floors, and no facilities to wash hands.

In practice, participants dispose of excreta either by burying it at a distance far from their home or burying a latrine pit in place when it had reached capacity and digging a new one. Participants note that they witness improper disposal of excreta in their communities, for example dumping too close to homes and water sources, which they are aware can lead to the spread of disease, such as cholera, diarrhoea, and other stomach illnesses.

"Most people dig a pit latrine, and when the pit is full, they bury it and dig a new pit. However, some people have built a septic tank instead of a pit, intending to reuse it after evacuating its contents somewhere far from the village when it fills with waste."

Husband, Faryab province

With no access to rubbish collection services, participants report either burying or burning their household rubbish. In one location, a community-led initiative had resulted in the preparation of a designated shared space for rubbish disposal.

"Community elders and the Imam of the Masjid have dug a ditch, and we throw it there."

Lactating woman (PWD), Faryab province

Practices Related to Handwashing

Participants report washing their hands at specific points throughout the day, including after using the latrine, before and after eating, and after waking up in the morning, when breastfeeding, cooking, changing diapers or clothes for a child, and after touching animals. However, handwashing was not always done using soap, with participants noting that they wash their hands with soap only when there is visible dirt on them.

"We are using water, and whenever needed, we also use soap. For instance, if it is too dirty, then we use soap, but mostly we use water."

Husband, Badakhshan province

Participants state that they do not have specific rules around handwashing – how frequently they do it, for how long, and with what materials; and that these aspects depend on what is available and what activities they are undertaking. Furthermore, participants mention that they do not have a specific place for handwashing, and generally wash their hands in the yard at home with the help of an *aftabeh* (plastic pitcher). Access to adequate handwashing facilities near the latrine or in a bathroom is very rare among participants.

Practices Related to Menstrual Hygiene

Findings indicate that the myths around menstruation described by participants are often translated into practice, including restriction of movement and activity during menstruation, and changes in diet. Participants mention changing the type of food they eat during menstruation, specifically to avoid cold, sour and bitter foods, and to consume more hot food and drinks, including green and black tea. They note that they keep themselves clean by washing with soap, water, Dettol and Pyodine (a broad-spectrum antiseptic). They mention avoiding excessive physical activity, such as heavy lifting, walking, and running, and some avoid going outside at all while they are menstruating. These behaviours are believed to prevent heavy bleeding and maintain good hygiene. They are also associated with social norms and taboos around menstruation, that deem it as shameful and negative.

"Yes, I prefer not to work anymore, not to go outside, not to touch the water, and to continue resting and eating warm food."

Lactating woman, Herat province

Whilst participants report buying or making menstruation cloths, disposable 'diapers' are also used, particularly during travel or when attending events. The frequency with which women report changing their menstrual cloth is dependent on the amount of bleeding experienced, with some mentioning that if bleeding was minimal, they may not change the cloth until the next day. Participants mention washing their menstrual cloths with soap or washing powder and drying it in the sun or by a heater. Once cloths were considered unusable (usually between a few months and a year, and up to 9 years), women report disposing of cloths in the general garbage. Participants mention that storage and disposal of menstrual cloths is done out of sight, due to feelings of shame and embarrassment.

"We put it in fire. In a plastic bag outside the toilet, we keep it, and then we burn it. Because it is not appropriate to throw it outside like that, and it is also considered a sin."

Pregnant woman, Herat province

4.1.5 Barriers

Key informants and target audiences identify both practical and environmental barriers to achieving safe WASH practices. Across target provinces, disrupted water supply and sanitation systems, due to natural disasters like earthquakes, floods, and drought, as well as the impacts of war, mean that water is less safe while becoming increasingly scarce. Target audiences highlight the seasonal changes in water supply bringing additional challenges to accessing water, with wells drying out in summer and water freezing in winter. Practitioners note that the most vulnerable people in the community, including older people, women, and children of internally displaced people (IDPs) and refugees, are disproportionately impacted by such disruption.

Participants highlight the key barriers they face as a lack of practical access to water; lack of clean water, the capacity to safely store it, and concerns about wasting scarce water supply for washing; financial constraints; lack of access to, and the high price of, hygiene products (such as soap); lack of facilities for handwashing, sanitation, and hygiene; lack of access to appropriate menstrual hygiene products; and high costs of heating water in winter. Furthermore, participants lack knowledge and awareness of good WASH practices. Elderly people and people with disabilities

face heightened challenges, particularly around accessing enough safe water for drinking and washing.

"It is difficult for everyone. We have a grandfather and a grandmother who are very lonely and face many issues with water. Getting water from the pipeline in winter is challenging for everyone. Water was not coming yesterday and the day before yesterday, causing much inconvenience. A handcart is used to bring water, but it is done with much difficulty. Therefore, there is a need for a small boy to be continuously present."

Pregnant woman, Daikundi province

4.1.6 Enablers

Participants report that they would be encouraged to take up better WASH practices if supported by NGOs and government to gain better access to water – specifically constructing wells, installing hand pumps, building sanitary public and private latrines, and developing water supply systems. They also mentioned the distribution of hygiene kits, and community-level awareness raising of WASH practices and the importance of handwashing and menstrual hygiene. Participants suggested awareness raising could also be implemented through television and radio, and via doctors, health care workers, and information pamphlets at clinics, as well as sessions in schools.

4.2 Nutrition

4.2.1 Available Services

Support to nutrition services described by key informants include screening for Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM) for mothers and children under five, counselling in breastfeeding and the distribution of food, including super cereal, micronutrient-rich and fortified foods, and formula milk, for malnourished mothers and children.

With the support of community volunteers, consortium partners implement sessions in villages addressing health issues such as measles, polio, and nutrition topics. Community Health Workers (CHWs) and Community Outreach Officers are trained to provide information and to cover screening, vaccination, and referrals for complicated cases. Key informants note that they facilitate mother-to-mother support groups and male forums to contribute to community training on health and nutrition. Family Mid-Upper Arm Circumference (MUAC) initiatives involve volunteers in health sub-centres distributing MUAC tapes, conducting screenings, and providing information on malnutrition and pregnancy services.

Participants cite the availability of nutrition services at health clinics and through humanitarian organizations, such as WFP and UNICEF. They report that these organisations distribute nutrient supplements, including Ready-to-Use Therapeutic Food (RUTF) and Ready-to-Use Supplementary Food (RUSF) and micronutrient powder, to malnourished pregnant and lactating women and children under five.

4.2.2 Access to Services

Examples of successfully accessing nutrition support and services via health clinics are limited among participants. Among those who had accessed these services, participants report receiving RUTF or RUSF, as well as micronutrient powder for their children and themselves. Notably, participants report receiving nutrition support during a PNC visit. However, participants reported that nutrition support and services are not always available, are in high demand and limited supply, and are not always distributed fairly. Those who are unaware and unable to access nutrition services resort to utilising traditional methods, such as feeding children with cow's milk and banana, and using herbal medicine.

"In our community, those who are aware of malnourishment go to the clinic for treatment. However, those who lack information about it engage in home-based treatments and traditional medications. They might give the child banana or cow's milk in the hopes that the child will gain weight, as was done in the past."

Lactating woman, Ghor province

4.2.3 Knowledge

Knowledge of appropriate nutrition for pregnant and lactating women, newborn babies and children under five is varied, with participants citing a mix of recommended practices and traditional beliefs.

Participants described the importance of feeding a newborn baby colostrum, the benefits of breastmilk, in some cases the recommendation to exclusively breastfeed for at least six months and to continue breastfeeding for two years. However, traditional nutritional approaches continue to be advised by mothers-in-law and elders. For example, participants report being advised against feeding their newborn colostrum, or to give babies animal fat along with colostrum immediately after birth to "clear the stomach". Additionally, participants believe that giving herbal medicines such as Amaltas Phali – Cassia Fistula Pods and flixweed, to children under six months is appropriate when mothers do not have enough breastmilk.

"After childbirth, I gave colostrum to the child. Along with that, I also gave animal fat because the elder women in the family advised me to do so, saying it is beneficial to clean the child's stomach. My mother-in-law specifically instructed me to do this. However, I gave the colostrum to the child half an hour after his birth because it is very beneficial."

Lactating woman, Ghor province

The benefits of breastfeeding are largely understood by participants, although there are gaps in knowledge when it comes to the importance of exclusive breastfeeding. Husbands report that breastmilk is the best food for the baby and is unique from other milk as it helps the baby to grow, as well as avoid diseases. Mothers-in-law and pregnant and lactating women demonstrate further knowledge, reporting that colostrum is the first vaccine for a child against disease, helps the child to grow and avoid malnutrition, and that feeding a baby breastmilk reduces the risk of breast cancer for mothers.

"Breast milk helps protect the child from malnourishment and various diseases. Additionally, it's beneficial for the mother as breastfeeding can protect her from breast cancer."

Pregnant woman, Nangarhar province

Participants demonstrate awareness that pregnant and lactating women, as well as children under five, need nutritious, 'fortified' food which has vitamins and

nutrients. Despite a lack of clarity on what the term 'fortified' means, or what specific foods are fortified, participants report that it is important to include a range of foods in a diet, including fruit and vegetables, meat, diary, and legumes.

"I'm not sure about the exact meaning of 'fortified food', but 'enrich' in the local term may imply food that is nutritious and helps the baby become strong. The food I give to my son is clean and semi-solid, and I believe it contributes to his health. Yes, we buy it for the sake of his health because clean food is trustworthy."

Lactating woman, Nangarhar province

Participants demonstrate a basic understanding of what causes malnutrition in women and children under five, citing issues with breastfeeding, not eating the right food or cooking food properly, and breastfeeding mothers not eating enough food and vitamins, as the causes of malnutrition. Understanding of the signs of malnutrition in mothers and children under five is more comprehensive, albeit with a mix of accurate and inaccurate symptoms, with participants reporting key signs as slow growth of baby, weakness, losing weight, vomiting, diarrhoea, yellowing of skin, swelling of stomach and eyes, low appetite, and losing hair.

"In children, symptoms of malnutrition include thinning of the hands and feet, hair loss, and inflammation around the eyes. Women may experience symptoms such as anaemia. These are things we have heard about from clinics and doctors."

Pregnant woman, Nangarhar province

4.2.4 Practice

Despite awareness of the recommendation to exclusively breastfeed a child for the first six months, in practice participants were often unable to do so. Reasons for this include a lack of breastmilk, the perception that the child was not sufficiently fed through breastmilk alone, a child refusing to take breastmilk (which mothers believed was bitter), or becoming pregnant again quickly and no longer being able to breastfeed. Where breastmilk was unavailable or deemed insufficient, participants report feeding their children food like biscuits, plant oil, animal fat, curd, liquefied rice, cereal and cow's milk. Limited reference was made to feeding the child with milk powder.

"Yes, we were giving cow's milk, butter, animal fat and biscuits as well because my breast milk was not sufficient alone. And I was giving breast milk ten to twelve times a day."

Lactating woman, Ghor province

Participants report breastfeeding their children for the first two years, noting that breastmilk was recommended as the only preferred solution for a baby. Other reasons for breastfeeding for the first two years include preventing pregnancy and that two years is the appropriate period according to Islam. Participants report introducing complementary foods to children after they reached six months of age, including 'soft' foods such as *shola* (rice), eggs, yogurt, banana, bean sauce, vegetables and liquified foods. Over the age of two, a child eats normal food with the rest of the household.

Family heads, generally men, make decisions and are tasked with purchasing food, while mothers-in-law contribute to these decisions, particularly around food for pregnant and lactating women. Husbands and mothers-in-law confidently listed the range of nutritious foods important for pregnant and lactating women and children to eat. However, in practise it is budget, rather than need, that dictates the type of food available in a household. Pregnant and lactating mothers report eating the same food as normal, and that all members of the household eat the same food. They note that budget constraints and affordability of food was the main factor in determining what they ate.

"Sister, economic problems are a reality and most of what we use on a daily basis is what we also used during pregnancy. Sometimes fruits may be available to eat, but in our village this is how the lifestyle is

– when a child is born we rely on traditional practices like using animal fat. My mother-in-law prepares things like animal fat and *leeti*, saying they are good for the baby and somehow also provide strength to the woman as well."

Lactating woman, Nangarhar province

"The main issue is that people with connections or who know someone can receive assistance easily. However, poor people who lack connections may have to wait longer or may not receive anything at all. This disparity is the main problem."

Mother-in-law, Nangarhar province

4.2.5 Barriers

Barriers to accessing a healthy diet are described by participants as financial constraints and high food prices, lack of knowledge about what foods constitute a healthy diet, lack of awareness among family members (specifically those making the decisions on what food to buy), and distance to the closest market or bazaar.

Participants report that while they are aware of nutritional support and supplements available through health clinics and via NGOs, there are a number of barriers to accessing them, including lack of distribution; the need to visit healthcare clinics to receive the support and a lack of transport to reach clinics; high demand and long queues for distribution and nepotism of staff in distributing supplements; and the inability of women to visit health centres without a male family member. A belief that RUTF and RUSF can cause gastroenteritis was also mentioned.

Key informants also cite economic constraints and the high price of food as the key barrier to families purchasing the amount and type of food they need to achieve a healthy, nutritious diet. As a result, practitioners see a high prevalence of malnourished mothers and children in the community, accompanied by anaemia, iron deficiency and a lack of Vitamin D and other essential vitamins. Key informants note that moderate acute malnutrition (MAM) is not considered to be a significant problem by families and is often left unaddressed, leading to complications during births and the delivery of underweight children, continuing the cycle of malnutrition. Furthermore, cultural beliefs and traditional practices mean families choose not to engage in some health and nutrition services, highlighting the urgent need for NGOs to provide awareness on the short-term and long-term effects of health and malnutrition diseases.

4.2.6 Enablers

Participants note that enablers for them to achieve a healthy, nutritious diet would include good economic conditions and lower food prices; assistance from NGOs and INGOs and government; awareness raising of good nutrition practices and services available among communities and influencers, and support and advice for families (particularly mothers-in-law and husbands) on how to achieve a nutritious diet; availability and accessibility of health clinics; the ability to borrow money for purchasing food; and the availability of livestock for milk, yogurt, and other dairy products, as well as the ability to generate income from selling home-grown produce (such as eggs) to buy other food.

Participants received information on nutrition for children and pregnant and lactating women from midwives and doctors, and report that NGO health staff and mobile health teams had provided awareness sessions on nutrition previously. Other sources of information about nutrition include family, friends and elders, as well as radio, social media, and television.

"We don't have a television, but my father-in-law listens to the BBC Radio. From the programmes on the radio, I have learned about what pregnant women should eat and what they should avoid, as well as what specifically they should eat after delivery. So basically, I have gathered all this information from the radio."

Lactating woman, Nangarhar province

4.3 Maternal and Child Health

4.3.1 Available Services

Maternal and Child Health services play a crucial role in ensuring the well-being of pregnant and lactating women, as well as children under five years old. Key informants note that their organisations support maternal and child health by delivering essential healthcare infrastructure, including strategically located health posts, ensuring access to birthing facilities in underserved areas. They provide capacity building to healthcare professionals – including doctors, nurses, midwives, trainers, supervisors, and vaccinators, aimed to enhance the skills and expertise of the healthcare workforce across Afghanistan.

Key informants also report that for pregnant and lactating women, interventions include a comprehensive maternal and child health education, covering topics including Antenatal Care (ANC), Postnatal Care (PNC), and delivery services, supplemented with the distribution of maternal and child health handbooks to empower mothers with essential information. These awareness initiatives expand to cover family planning and mental health counselling. Dedicated health services for children under five include the Essential Programme on Immunisation (EPI) vaccines for diseases like measles and polio, treatment for Acute Respiratory Infections (ARI), and the provision of necessary supplements and medicines. Key informants note that they aim to provide mobile services that move between underserved communities to provide key maternal and child health services. However more recently, this type of service has been disrupted due to restrictions on movement imposed by the DFA, particularly on female staff, making access to remote areas particularly challenging.

4.3.2 Access to Services

Key informants note that remote rural areas lack maternal and child health services, with limited access to clinics and hospitals, and an undersupply of medical equipment, adequately trained staff, and medicines. Key informants also note a lack of a referral system in some clinics, leading to difficulties in managing complicated cases. These observations reflect the experiences of target audiences, with participants reporting significant challenges in accessing maternal and child health services, due to living long distances from clinics and hospitals, poor roads and a lack of transportation. They also cite financial constraints around accessing services, in terms of paying for transport, as well as paying for required medicines and care. Some respondents talk of borrowing money to pay for services, including private hospitals. Participants who visited health clinics and hospitals report overcrowding and long waits, as well as a lack of medicines and services. Disrespectful behaviour of staff was also mentioned.

Key informants and participants note that women are often not permitted to go outside without their husband's permission, and husbands often discourage them from going to health clinics for services. This means that many women have home births and rely on ANC and PNC advice and support from family members and traditional healers, resulting in high morbidity and mortality rates, and children born with disabilities.

4.3.3 Knowledge

Participants are aware of the need for women to rest and undertake lighter physical activities while pregnant. Mothers-in-law report guiding pregnant women to avoid certain activities during pregnancy, such as lifting heavy objects, excessive walking, prolonged sitting, and going outside; and encouraging pregnant women to prioritise rest. Additionally, they report that pregnant women should eat healthy and nutritious food, such as vegetables, yogurt, and meat, for their own and their babies' health.

"I've mentioned not to lift heavy objects, avoid prolonged sitting, and focus on eating nutritious food for maintaining energy levels."

Mother-in-Law (PWD), Herat province

However, understanding of the purpose and importance of regular ANC check-ups during pregnancy is somewhat limited and generic. Participants demonstrate some knowledge of the number of times a pregnant woman should attend ANC check-ups at health clinics – commonly cited as three-to-four times during pregnancy (WHO recommends at least four, and ideally eight ANC visits)[5]. Participants identified key aspects of ANC check-ups as monitoring blood pressure, checking iron levels, monitoring the baby's weight and position, and the overall monitoring of the health of mother and baby. The provision of folic acid tablets, vaccines, and nutritious food is also cited.

"The mother needs to go in order to check the blood pressure, whether it is high or low, and to assess the child's well-being, including their shape and weight. All this information can be obtained through regular check-ups."

Mother-in-Law, Nangarhar province

Findings indicate some misconceptions and fears around ANC check-ups among pregnant and lactating women. Participants report that a woman only needs to attend an ANC check-up or visit a clinic or hospital if they experience serious health issues during pregnancy. Health issues considered serious enough to require hospital treatment include fever, bleeding, and "womb problems". A belief that ultrasound scans can be harmful was also mentioned by participants.

"I do not have much information because I have not been to the hospital. I didn't have a serious problem that required me to see a doctor. There's a belief that even ultrasound scans can be harmful and can delay the due date for delivery. If it's not a serious problem, then frequent check-ups may not be necessary."

Pregnant woman, Ghor province

Participants are aware of the benefits of institutional delivery, citing access to better services and doctors to cope with any issues that may arise during birth. Whilst there is awareness of the need to pre-arrange transport to the hospital for delivery, there is limited mention of the need to save money for emergencies or to identify blood donors.

"In the hospital, we won't encounter any difficulties, and it's the safest place for both me and the child. The hospital is the best option because it has medicines, injections, serum, and doctors available, ensuring we won't face any issues".

Lactating woman, Badakhshan province

Knowledge of key preparations necessary for home deliveries tend to be rudimentary in nature. For example, participants mention warming the room, having a clean razor blade, scissors, and thread for

5 UNICEF (January 2024) *Antenatal Care* [online]. Available from: https://data.unicef.org/topic/maternal-health/antenatal-care/ [Accessed May 23 2024].

cutting and tying the cord available, and ensuring the presence of traditional healer or midwife and other women for helping. Participants also mentioned ensuring the room is clean (including smoking *peganum harmala*, which is believed to act as an antimicrobial disinfectant) and placing a plastic bag or sheet underneath the woman during labour. There is limited awareness of danger signs to look out for during labour and childbirth, which participants cited as vaginal bleeding, fluid draining, and body pain during birth. Participants note that complications during delivery could lead to a caesarean section, however, in practice no participants mentioned preparing for complications or emergencies during a home delivery, such as arranging transport to a hospital.

"When a woman is delivering at home, the room temperature must be warm, and a midwife along with two or three other supportive women must be present. A clean blade to cut the cord must be available, and the woman's abdominal area, along with her backside, should be rubbed with moisturiser.

Pregnant woman, Ghor province

Participants note that they get information regarding birth preparation and delivery from family and community members, most commonly mothers, mothers-in-law, and elders. Television and radio are also mentioned as sources of information.

Findings indicate that knowledge of PNC is focused on basic, home-based care and reliant on traditional knowledge. For example, participants highlight that after delivery, mothers should be allowed to rest, maintain good menstrual hygiene, eat healthy, nutritious food, and should avoid doing heavy chores for several weeks. Traditions stipulating the type of food a woman should eat and avoid after delivery are considered important, particularly among the mothers-in-law interviewed.

"After delivery, we abstain from offering cold water or onions, as well as pepper and beef. Instead, we provide semi-solid eggs. As Uzbek people, we also incorporate animal fat into the diet. Additionally, we include foods like *Leeti*, chicken, sheep, and goat meat."

Mother-in-law, Faryab province

Post-natal danger signs mentioned by participants include vaginal bleeding, swelling, high or low blood pressure, back pain, stomach-ache, fever, and headache. Participants note that mothers must be transferred to hospital if suffering from these issues. Respondents did not demonstrate any knowledge about pregnancy diabetes and depression after delivery.

"What are the danger symptoms to pay attention to during or after delivery? Danger signs such as bleeding, both types of blood pressure [high or low] which can even cause death."

Mother-in-law (PWD), Herat province

Findings indicate limited awareness of the danger signs in newborns, particularly among male participants. Pregnant and lactating women and mothers-in-law identified some of the key health issues for newborn babies, including hepatitis, pneumonia, diarrhoea, measles, severe fever, and severe vomiting. Participants note that a baby should be transferred to hospital if any of these issues persisted after traditional, at-home treatments were attempted.

"Diarrhoea, vomiting, pneumonia, and ear pain are signs of danger for children. We have to provide home-based treatment; if it doesn't help, then we can take the child to the doctor."

Lactating woman, Ghor province

Findings indicate very limited understanding of the purpose and importance of clinical PNC check-ups. Participants report that women only need PNC check-ups if they are experiencing health issues, while others suggest two or three PNC check-ups, at most, are required. In describing the purpose of PNC visits, participants describe health checks for the mother (such as checking for iron deficiency), monitoring the health of the child (including malnutrition), breastfeeding support, and receiving vaccines.

Participants highlight the need for mothers and newborn babies to receive vaccines, including measles, tetanus (TT), pneumonia, hepatitis B, hepatitis C, polio, and Pinta. However, participants were not clear on the number of doses required for each vaccine. A contrasting view among them highlighted the belief that vaccines were not necessary unless a mother or child faced specific health issues.

Sources of information and advice about vaccines include family members, midwives, doctors, and vaccinators, as well as radio and television.

"Yes, vaccines such as those for measles, tetanus, pneumonia, and more are recommended. My husband, mother-in-law, and father-in-law advised me to get the vaccine as it is beneficial and protects children from various diseases, so it's a good idea."

Lactating woman, Badakhshan province

4.3.4 Practice

Findings indicate that knowledge and awareness of ANC does not necessarily translate into real life practice. For example, pregnant and lactating women report that they had continued to undertake many chores throughout their pregnancy and found limited time to rest due to the daily necessities of tending to livestock, collecting water, washing and cleaning.

"We have many problems because we have livestock, and we have to provide water and hay to the livestock and do the chores as well. That's why I cannot rest."

Pregnant woman, Ghor province

Furthermore, pregnant and lactating women report attending just two or three ANC check-ups at most during pregnancy, while others had not attended any at all. Mothers-in-law described having insisted that pregnant women attend ANC check-ups, however this conflicts with reports among pregnant and lactating women who state their mothers-in-law did not encourage (and often restricted) their attendance at health clinics and preferred to advise them based on their own experiences of pregnancy.

Findings show husbands and mothers-in-law make the decision about where to deliver a baby. Institutional delivery (at a hospital or clinic) was the preference for participants, however, those living in more remote rural areas report having home births. Reasons for having a home birth include practical barriers to accessing a hospital or clinic (for example, long distances to facilities, high cost and unavailability of transportation, and needing a male family member to accompany them) and prevalent attitudes against institutional delivery, including

a preference for traditional healers, fear of clinic delivery, and the influence of mothers-in-law who had experienced home delivery.

"I was told to deliver at home, and my mother-in-law also assured me that there was no need to go to the hospital and that everything would be fine at home. My family didn't give me permission, saying that everything happens according to God's will and that home delivery is also possible. She mentioned that our neighbour is a midwife, so in case of any issues, we could call her for assistance."

Pregnant woman, Ghor province

Attendance at PNC check-ups was reportedly uncommon among pregnant and lactating participants, who believe it is only necessary to do so if the mother or child faced health issues, or after a caesarean delivery. Among participants who had visited a clinic for a PNC check-up, they had done so only because they were experiencing pain, vaginal bleeding, had a caesarean section or because their child was sick.

"No, I have not gone because if there is no serious issue, then there's no need for a checkup."

Pregnant woman, Ghor province

Those participants who attended PNC visits at a clinic mention receiving useful materials and assistance, including mosquito nets, hygiene kits, and nutritious food.

"We have taken her to make sure there are no health problems. We also went to get a mosquito-preventing net or any other necessary items for the child. Additionally, we checked the child's weight and went there to receive any other available beneficial thing for the child."

Mother-in-law, Nangarhar province

While findings do not indicate widespread reluctance towards vaccine uptake, specific experiences among participants did highlight some of the barriers to achieving full vaccination. For example, one participant described how her first child had experienced fever and discomfort due to a vaccine, leading her and her husband to avoid further vaccine uptake, for both her and her second child. Another participant described agreeing to be vaccinated when vaccinators came to their home, despite believing they were not necessary.

"I vaccinated my first child, but he developed a fever and became more uncomfortable, crying a lot. As a result, my husband didn't allow me to vaccinate him again. That's why I didn't vaccinate my second child, and I haven't received any vaccines myself because I didn't face any problems."

Lactating woman, Ghor province

4.3.5 Barriers

Practitioners and target audiences alike note that a key barrier to the uptake of maternal and child health services is a lack of awareness and understanding of the importance and benefits of these services, and of how to access them. This is particularly the case among underserved communities, and likely a result of limited engagement with these services historically. Participants also highlight many practical barriers to their uptake of maternal and child health services including a lack of supply and inaccessibility. Specific issues cited include a lack of health clinics (and high demand at the few available), lack of staff at health clinics, lack of adequate health services within the clinics (such as X-ray), insufficient availability of medicine, long distances to health facilities, damaged roads and pathways, lack of vehicles and high transportation costs. Furthermore, unsupportive attitudes of family towards women visiting clinics, preferences for traditional treatments and local healers, stigma and fear around institutional health care, restrictions associated with mahram, and not allowing women to go outside are also identified as barriers to the uptake of maternal and child health services and positive practices.

"We faced many problems when my wife was pregnant, and I took her to the hospital. It was very difficult because I didn't have a vehicle or money to rent one. And when we reached there, we always needed money to buy medicine or other things. If the medicine wasn't available at the hospital, I had to go get it, which was very problematic. We couldn't even afford to buy fruits for the patient."

Husband, Ghor province

Key informants also highlight lack of supply as a barrier they face in delivering maternal and child health services, citing a lack of trained health care staff and supply chain issues. There has been a notable decrease in hospital and clinic staff, with financial constraints within public healthcare leading to minimal compensation and the resignation of many skilled workers. The supply of medicine faces significant delays throughout the country, due to funding constraints, transportation issues and seasonal outbreaks. Furthermore, limited access to crucial resources, including electricity and water, as well as inadequate health facilities, pose additional challenges in some areas. Key informants also note that many health staff lack adequate, practical training due to a shortage of Essential Programme on Immunisation (EPI) vaccine trainers and Community Health Worker (CHW) trainers, hampering the dissemination of vital health knowledge and support to the community. They also note the inadequacy of training resources, meaning training is often undertaken using out-of-date or poor materials, hindering the effectiveness of training programmes.

Key informants also note increased challenges to implementing projects to support maternal and child health. For example, the DFA has enforced policy changes that have made the transfer of mobile teams to fixed clinics more difficult through restrictions on the movement of healthcare workers between villages. Practitioners describe the challenges of reaching agreement between donors and health officials on the needs of communities and most effective means to provide essential healthcare in Afghanistan, with a mismatch of what donors wish to fund and what health officials are willing to authorise. For example, donors often want to offer mobile services to reach remote communities, while the Ministry of Public Health wants to build more permanent clinics. This prolonged process of establishing Memorandums of Understanding (MOUs) with the DFA has resulted in significant project delays.

4.3.6 Enablers

Participants describe several factors that would enable them to access and avail maternal and child health services, including the support to attend check-ups from their family, particularly husbands

and mothers-in-law; information on ANC and PNC from experts, doctors, midwives, and health staff; availability of clinics nearby; availability of appropriate services, skilled staff and adequate medicine at clinics; transportation to health clinics; and financial support. They also mention awareness raising activities that highlight the benefits of maternal and child health services for mothers and children under five, particularly among mothers-in-law, and husbands, as well as the wider family and community. They suggest using community outreach and health staff visits, as well as radio, television, and internet interventions. Additionally, participants cite the distribution of hygiene kits and nutritious food in the clinics as enablers of maternal and child health service uptake.

"If the family allows and encourages me, or if the hospital is nearby, then I am interested and will be motivated to go for the check-up to the doctor. To persuade the community, husbands and families have to support the women. Another thing is that if the organisation's staff go to the villages and motivate people, raising their awareness, or if the government has the means to build hospitals in remote areas of the country for people to access, that will also urge people to take their children and women to the doctor."

Pregnant woman, Ghor province

Reflecting target audiences' calls for community outreach to raise awareness of maternal and child health, key informants see face-to-face, community-based sessions as the most effective means to transfer this information to audiences, particularly for reaching remote areas and vulnerable people.

5 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusions

Findings indicate that currently available WASH, nutrition and maternal and child health services are not reaching target audiences across the DAWAM provinces included in this study, and that these services are facing significant challenges to delivery within the context of restrictive policies, extremely limited funding, supply chain issues, and lack of adequately trained staff. These challenges are reflected in the limited access to services reported by participants.

Knowledge of key WASH, nutrition and maternal and child health practices among participants is also limited and generic. Whilst participants demonstrate some knowledge of recommended practices, they lack understanding of the importance and/or benefits. This means that knowledge is not necessarily translated into practice, where practical barriers or unsupportive attitudes make uptake of positive behaviours challenging. For example, whilst participants are knowledgeable about the type of foods needed to provide the nutrition a pregnant or lactating woman needs to support her baby, in practice it is budget, rather than need, that dictates the type of food available to her.

Furthermore, WASH, nutrition and maternal and child health practices remain highly influenced by the traditional beliefs and experiences of elder women, especially mothers-in-law. Institutional delivery and attendance of ANC and PNC check-ups are particularly prone to misconceptions, negative attitudes and unhelpful social norms. And traditional beliefs around nutrition for newborns continue to put babies at risk of potentially harmful practices.

Perceived barriers to people accessing and availing WASH, nutrition and maternal and child health services are consistent among practitioners and target audiences. Key informants and participants alike describe the overarching barriers as a lack of access to clinics, hospitals and services;

financial constraints; lack of knowledge and awareness of available services and positive practices; unhelpful social norms and traditional beliefs; and a lack of availability of essential medicines and hygiene materials.

Enablers to uptake of services and positive practices include support to overcome practical barriers, such as availability of transport, financial support, development of more clinics and facilities; as well as knowledge and awareness-raising in communities. Respondents highlight that having the support of family members and key influencers, in particular husbands and mothers-in-law, to engage with available services would enable them to adopt more positive WASH, MCH, and nutrition practices.

5.2 Recommendations

The following recommendations are based on formative research findings and developed through discussion between research and programme teams.

Address gaps in knowledge and understanding about key WASH, nutrition and maternal and child health principles, with a focus on understanding the importance and benefits of the uptake of positive practices and available services. In terms of WASH, this may include information around how and when to treat water to make it safe to drink, and the importance of handwashing using soap. In terms of maternal and child health services, this may include awareness raising around the purpose of ANC and PNC check-ups, even for well women and children; dispelling myths and fears around what happens during these check-ups and reinforcing the benefits of attendance.

Dispel traditional beliefs and highlight practices that continue to cause harm. Interventions should sensitively address the issues associated with traditions around WASH, nutrition and maternal and child health. For example, highlighting potential harm caused by feeding newborns with anything other than breastmilk or milk formula, and supporting families to access nutrition and breastfeeding services. In the case of maternal and child health, this may include normalising the use of health centres and medical professionals for reproductive, maternal, newborn and child health services, and helping older women to be supportive of mothers doing this. For WASH, this may include encouraging community-led solutions to end open defecation through a focus on changing attitudes and behaviours, as well as addressing taboos around menstruation.

Provide support to overcome practical barriers to accessing services and support. For example, addressing transportation issues for families needing to access health centres by encouraging people to save money for transport or emergencies, or providing examples of how communities can support people to access health care when they need it, helping people to engage with mobile health workers and vaccinators. In terms of WASH support, distribution of hygiene kits should continue to provide people with free basic hygiene products alongside information on the benefits of practicing good hygiene.

Engage remote rural communities directly via face-to-face sessions on WASH, nutrition and maternal and child health, harnessing the support of trusted local stakeholders and influencers. Utilise effective platforms including schools, mosques, and community *shuras* for awareness-raising and knowledge-sharing sessions. These initiatives should be supplemented with media content, via radio and television to reinforce learnings and reach audiences on a broader scale.

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