

The Nutrition Capitalization Report: Tdh projects in Afghanistan December 2003

1. Name of the projects:

Rustaq Post-Earthquake Rehabilitation Health Project, Mother and Child Home – Visiting Project Kabul, Mother and Child Health Project Kandahar and Street Working Children Project Peshawar. The strategy is to offer mother and child health care through home-visiting in Kabul and Kandahar, and providing mother and child health services through Rustaq clinic and mobile teams as well as providing expanded program for immunization in Rustaq district, and to look after the health of street children in Peshawar.

2. Country:

Afghanistan

3. Field:

Mother and Child Health care in Kabul and Kandahar provinces and Nutrition Activities through Health and Nutrition education and providing supplementary foods to the malnourished children and mothers as well as MCH services in Rustaq.

4. Relevant years:

This report will cover the period from January 1996 to July 2003 for MCH-HVP Kabul, May 2001 to July 2003 for Rustaq, August 2002 to July 2003 for Kandahar, and March 2002 to August 2003 for the Street Children Project in Peshawar.

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7. Implementation:

All the four projects are implemented by *Terre des hommes*.

8. Funding:

Rustaq project is funded approximately 56% CDB, 34% by SDC and 10% by Tdh Germany. MCH-HVP Kabul is funded approximately 59% by Tdh Lusanne and 41%

by Tdh Germany, while Kandahar MCH-HVP is being financed 39% by CDB, 51% by SDC and 10% by Tdh Lusanne.

9. Background:

Afghanistan has some of the worst social indicators in the world, ranking 169th out of 175 countries according to the 1996 UNDP Human Development Index, and holding the lowest position of any country in the world in the Gender Disparity Index (a composite of male:female life expectancy, literacy, educational attainment and income). The under-five mortality rate is the fourth highest in the world and the highest outside Africa, with one in four live-born children dying before the age of five years. Complicating the already dire situation for Afghan children is a pervasive community consciousness that the risk of child death in the early years is best countered by having more children, thus contributing, in turn, to the higher probability of children dying.¹

Kabul MCH Project

The *Terre des hommes* Mother & Child Health - Home Visiting Program (Tdh-MCH-HVP) commenced in January 1996 with the prime aim of reducing maternal and infant mortality in the city of Kabul. Impetus for the project stemmed from recognition that the health service infrastructure of Afghanistan had been severely disrupted as a result of long-standing war, conflicts, deprivation and population dispersal.

The project directly responds to the needs of mothers who have no access to any health facilities in Kabul: the maternal and child health situation continues to be seriously affected by long-term conflict, low socio-economic status, population movement, shortage of female health personnel and limited access of women to health care services. The traditional reluctance of women to use male health providers, poor health awareness, high illiteracy and family poverty contribute to the under-utilization of health services.

Rustaq Post Earthquake Rehabilitation Health Project

Terre des hommes (Tdh) began with the project in May 2001. Emphasis is on basic primary health care (limited MCH and curative care) and preventive health care (health education and EPI services) for the population of Rustaq and 15 villages.

It focuses on EPI for the whole district with all children vaccinated by the end of 2003, on health education implemented on town, village and community level of at least 15 villages and outreach programs with mobile doctors for 15 villages installed. In addition a MCH clinic in Rustaq is fully operational as a reference clinic.

¹ UNICEF, Lost chances - The changing situation of children in Afghanistan, 1990-2000

Kandahar Maternal Health Project

The project began within an emergency context in July 2002. Through the MCH-HVP program the support and contact provided by *Terre des hommes*' (Tdh) midwives to pregnant women, mothers and their newly born babies will improve the health care and is an essential service – considering the specific cultural requirements of Pashtun women who have little opportunities to leave their homes and with almost no access to maternal health facilities. The woman of the target area in Kandahar will receive awareness in a variety of health and maternity related issues such as: Deeper understanding of health as the complete state of physical, mental and social well-being. This includes the importance of food and kinds of food to be consumed during the pregnancy, importance of vaccination, breast-feeding and pre- and postnatal care and to refer them to MCH clinics for TT vaccination. The clients receive all necessary medicines, enriched food like BP-5 and birth kits.

Peshawar Street Children Project

In the crisis situations faced by many street and working children, service provision may well be a key element of the project. Drop-in centers create alternative environments for children whose lives are difficult. They are places where children can feel relaxed and comfortable, safe and looked after. They are places where children can talk to each other and to project workers, knowing they will be both listened to and heard. They are not places where they will be talked at or preached to, even though they should be places where they may be able to practice, learn or recover the skills and habits of good interpersonal relationships.

Offering nutrition, hygiene facilities, rest, recreation and counseling as well as health education is part of the program

10. Final aim and objectives

Expected outputs of the projects are to reduce the incidence of maternal and infant morbidity and mortality in part of Kabul City, part of Kandahar City and Rustaq region.

Access to health has been provided for urban and rural women who had limited opportunities. The particular aims are to reduce unnecessary maternal and infant mortality and to promote qualitative improvement in women's and children's health through preventive and curative support at village and city level.

Primary health care for rural families in 15 villages has been introduced through provision of medical mobile teams. Safe drinking water was provided to the people of 16 villages along with health education.

11. Evaluation:

An evaluation of MCH-HVP Kabul was made by the consultant Brenda Jenkins in December 2000 with the aim to evaluate the effectiveness and impact of the MCH

services for the project clients, and how the change has taken place in the client's attitude, beliefs, practice towards Maternal and Child Health care, and what problems they face.

As a result the whole project became more community-oriented, focusing also on a 'listening approach' in order to better understand clients' needs.

12. Significant fact observed and their analysis:

A three-day nutrition workshop was held in August 2003 in order to learn from project experiences. It was the first workshop of this kind for the Afghan staff and also the first opportunity to meet colleagues from three different project sites plus a colleague from a street children project in Pakistan.

It is important to note that all projects mentioned are directly implemented by *Terre des hommes*.

a) Interaction of the MCH project in Kabul

A team of very well trained professional midwives, a team of senior midwife supervisors, and two medical doctors, one of them the project coordinator, are independently implementing a maternal-child health project in Kabul city. Well organized, with a very high level of corporate identity and proven leadership qualities the team of 30 health professionals reach out to a very high number of mothers in need. Through a set of different intervention strategies, namely maternal health care (ante-, intra- and postnatal care), health education, nutrition and consultation, the project contributes significantly to decreasing levels of mother and infant morbidity and mortality rates within the project area.

b) Interaction of the Health Project in Rustaq

Mobile health teams of the project are visiting on a very regular basis all five sub-clinics in the villages in order to provide services to people from 15 villages in the surrounding areas. In these 15 villages teams of community health workers are in place and providing health education. The main Rustaq town clinic is rehabilitated, and more than 1300 mothers and children per month receive treatment, health education and regular immunizations. Measles campaigns are carried out again regularly, and no cases have been reported yet: an indicator of eradicating measles in Rustaq district. Numbers of patients with serious health problems are dropping due to the impact of preventive health care measures. Malnourishment in children is closely followed and children in project areas are safe. Village health care is implemented and villagers trust the performance of the mobile teams. EPI has been established and regular services have expanded to 173 villages of the whole district. Village-based health education is a success story and team spirits are very high. Village communities are learning that proper health could become a lifestyle issue.

c) Interaction of the MCH project in Kandahar

A local co-ordinator, Medical Doctor by profession, is in charge of the program, supported by a supervisor/midwife-trainer. A team of midwife supervisors and trainers in Kabul and the midwife trainer in Kandahar are supporting and training four teams who are in charge of the MCH-HVP program. An administrator is in charge of the MCH office. Women are referred to the MCH-HVP by MCH clinics, maternity hospitals and through community contacts. Babies and infants are referred by child hospitals for treatment at home. The midwives also refer mothers with new-born babies to MCH clinics for routine care and immunization, as well as complicated and high-risk mothers and new-born babies to hospitals for further treatment. Each team of midwives carries a midwifery kit, which contains essential drugs and delivery equipment. A book is carried for registration of the client, drug monitoring forms and mother and baby records. The midwives have to record every visit and assistance provided into these documents.

d) Interaction of the Peshawar Street Children Project

Health care provision must be backed up with, or develop into, health education. Health is considered to be a lifestyle issue. It is aimed to look at how children live from a health point of view. Where, with whom and how do they live, sleep and eat. How do they describe their own health problems? How do they think their bodies' work? For both street and working children the provision of health services is twofold, emergency or curative help first, then developmental work like health education, both of which can be activities in which children learn to help themselves. A health educator with outstanding professional experience is in charge of health issues for children, but health education is also offered to the families, especially mothers. A curative health unit is put in place, open for all children in need.

e) Recruitment strategies of project staff

Midwives, as project staff in Kabul and Kandahar, are recruited from the specific geographical areas of intervention. Each midwife performs an important community role and resides in the district that she serves. This enables her to visit families five days per week and to be available, if called, by family representatives to assist in a home delivery.

Due to the fact that health staff in Rustaq are from a different geographical as well as ethnic area, the project focused on the establishment of village-based community health volunteers in order to develop a project ownership identity.

f) History of projects

All health & nutrition projects in Afghanistan, including the Peshawar Street Children Project, have been developed within an emergency context of war, displacement and crisis. With the recent political changes in Afghanistan the health projects are undergoing changes from an emergency environment to a development approach.

g) Access to health facilities

Women are experiencing poor access to medical facilities, especially in Kabul and Kandahar. Women are unable to consult medical specialists for a variety of social, political and economic reasons. For example, many are discouraged from leaving their homes in the daytime and often cannot afford childcare to visit hospitals. After sunset even greater difficulties arise finding transport on the one hand and affording it on the other.

The situation is worse in rural areas like Rustaq, where there are no health facilities except weekly mobile teams within the project.

h) Food/vitamin supplementation and provision of medication

Terre des hommes midwives distribute iron and multivitamin supplementation to mothers. Due to high malnutrition rates in mothers the MCH Kabul project is also distributing food supplementation to the most needy clients.

Within the Kandahar and Kabul projects antibiotics are used for the treatment of maternal and newborn (up to six weeks of age) infection (like eye infection, Omphalitis etc) according to the HVP protocols since the link between infection and nutrition is well known. In addition the projects train mothers in clean and safe preparation and use of medicine.

Treatment for sick children and women are offered through a children and women OPD, and a Gynae/Obstetric OPD in Rustaq main clinic as well as mobile clinics. Supplementary food is provided to malnourished children, pregnant and lactating mothers as well as nutrition education.

i) Referrals

The positive impact of the project lies within the social sphere of the project contexts. The midwives have acted as very positive role models for other women as well as the whole community. It is a proven fact that also the men in the project area have always welcomed and are still welcoming the midwives. Many referrals are done by local shop owners and other local people from the communities. A system of referral is established between the project and the MCH clinics and hospitals. In case of serious complication or risk, mothers and babies are referred to MCH clinics or hospitals. Moreover, all women and babies are referred to MCH clinics for immunization. On the other side, MCH clinics and maternity hospital refer clients to MCH HVP project for home care.

All midwifery teams gather in the MCH clinic close to their area of intervention for one hour in the morning in order to prepare their work on the field and discuss referrals with MCH clinics' staff.

The CHWs in Rustaq villages refer the sick children and women to the mobile team and Rustaq clinic for treatment where they receive treatment, regular child immunization for the six killer diseases as well as Tetanus vaccine for all

childbearing-age women. The complicated cases are referred to Taluqan or Faizabad Provincial Hospital for further investigation and treatment.

j) Uniqueness of the projects

There is no other home service being offered in Afghanistan to women in need of ante-partum, intra-partum and post-partum care. Undoubtedly the work of the Tdh/MCH/HVP teams in Kabul and Kandahar have contributed towards making childbirth safer by the improvement of maternal and infant health.

The same applies partly to the Rustaq project: The mobile teams are visiting the villages in a very regular way, thus creating trustful relationship between beneficiaries and service providers.

k) Consistency

The projects are consistent with the cultural requirements of maternal health services within the Afghan context due to the careful implementations through home – and village visits. The projects respond for a long time to the published findings of UNICEF concerning maternal health² and related recommendations. The project is also clearly integrated within national policies for improving maternal and infant health.

l) Participation

MCH Kabul: Participation of the population concerned has been limited in the past due to restrictions (mobility, interaction and exposure) imposed by the Taliban regime. The continuation of the project has been severely threatened during the period from 1996 to 2001, and it was always in danger to be closed down by the Taliban authorities. Nevertheless the local population in the respective areas was always supportive and had a very positive approach towards the midwives.

Rustaq: Participation of the local population is quite high, as expressed by the number of community volunteers in the villages.

m) Local capacity building

Capacity building is focusing on human resource development within the *Terre des hommes*' team. The MCH project in Kabul has become a "self-runner" and has acquired all managerial capacities to act relative independently as far as implementation, reporting and administration is concerned.

² Lost Chances - The changing situation of children in Afghanistan, 1990-2000

n) Risk factors for nutrition

Family conflicts due to low economical situation and increased demands, second, third and fourth wives, early marriage and poor understanding between the spouses, intermarriages, forced marriages, the custom of bride-price and exchange marriage and related problems with husbands and mother-in-laws create depression and psychosocial disturbances for breast-feeding mothers, as well as influencing maternal nutrition.

o) Key problems of the target groups – related to nutrition

i. Poverty

Deeply-rooted cultural attitudes regarding pregnancy, delivery, breast feeding, baby care are threatening mother and child survival including extreme poverty, high illiteracy rate (more than 90% of project clients cannot read and write), malnutrition, poor hygiene and poor sanitation facilities. Many women and children of the target group are generally living in extreme states of impoverishment and austere home conditions. In many areas the 'habitable' places that represent homes are, in fact, remnants of bombed out buildings. Most of the dwellings are rudimentary and generally only served the purpose of very basic shelter for several families³. The main causes of maternal mortality are haemorrhage, infection, toxæmia and obstructed labour, in addition to indirect causes such as iron-deficiency anaemia, malaria, tuberculosis and hepatitis.⁴

ii. Fertility

Another key problem is the fertility rate of the target group: the fertility rate in Afghanistan has remained more or less stable since 1960, estimated at 6.9 in the late 1990s. Afghans adhere to the custom of large families. Recent surveys among Pashtun women noted desired numbers of children as between seven and ten, while economic considerations and deterioration in the mother's health were found to be common reasons for men and women to limit their fertility. Complicating the already dire situation for Afghan children is a pervasive community consciousness that the risk of child death in the early years is best countered by having more children, thus contributing, in turn, to the higher probability of children dying⁵.

³ Brenda Jenkins: Maternal and child health – home visiting programme, Kabul Afghanistan, 1996 - 2000

⁴ Lost Chances - The changing situation of children in Afghanistan, 1990-2000

⁵ ibidem

iii) Violence

Husbands are the primary perpetrators of violence against their wives though other male or female members of the husband's family may be perpetrators or instigators. Girls are more at risk of physical abuse if married young, between the ages of 12 and 15, purportedly due to having less understanding of how to assume the "duties" of a wife and being more likely to annoy the husband. There is effectively no support for female victims of violence with virtually no means of seeking redress within the husband's family, and she is often unable to return to her own family home as this would be considered shameful.⁶

p) Innovations

MCH Kabul Project

- i. Health Education: Specific objectives include health promotion and disease prevention through health education provided during each home visit. An added bonus of the home visiting programme is that other women within the compound, including mother-in-laws and young adult women (adolescents), and sometimes neighbours, also participate in the health education messages provided by the midwives. Many women gather together and cooperate to get a better understanding of issues, such as safe birth, hygiene, benefits of breast-feeding, supplementary food, benefits of vaccination, as well as gaining knowledge about diarrhea and its management at home, acute respiratory infection, family planning, etc.
- ii. Community Participation: Some mothers who well understand health education from the Terre des hommes' midwives are also voluntarily disseminating these health education messages to other women in the communities. Midwives work and live within the communities. Communities are therefore well informed about Tdh activities and highly participate in referring mothers and babies for support and transmitting information.
- iii. Family Planning: A survey conducted by the Tdh-MCH project, indicated clearly that family planning is a top priority need of the target group. 360 mothers, between 15 and 44 years old, have been asked about their need and wish for family planning. 98% of all women asked are interested in family planning. 92% of these women are not able to go to a hospital for family planning issues. 96% of the husbands agree in family planning. It is interesting to note that an average number of children in these families is given as 5,89 children with a maximum of 14 children per one mother. The distribution of the means (condom, pills, and injection) of contraception has gone very well. Terre des hommes' midwives mainly support clients who cannot go to MCH due to restrictions by their husbands or other family

⁶ ibidem

member, or due to economical restrictions.

Currently around 500 program clients are followed up with family planning supplies, and protocols are in place, which view birth control as the right of women.

- iv. Domestic violence: In a preliminary survey (end of 2002) the midwives asked several hundred mothers and found out that 56% were afraid of their husbands, 52% of the women were afraid to leave their homes, 33% were beaten or kicked by their husbands and 35% of women interviewed reported that they have suffered marital rape. As a result MCH midwives attended training programs for psychosocial counseling.

The survey was possible due to the trust and confidence towards the MCH home-visiting program, and due to the fact that these issues were continuously raised during health education sessions in the private homes.

MCH Kandahar Project

- i. Due to the problem of hiring skilled female health staff, the project employed mainly female community health workers.
- ii. Due to the specific and difficult situation the Kandahar project does not simply copy the whole approach of the MCH Kabul project. The Kandahar MCH project starts the same evolutionary process as the Kabul project in 1996.

Rustaq Project

- i. In order to better address the problems of Rustaq communities, Terre des hommes developed and implemented an integrated program approach: health, education and water & sanitation.
- ii. EPI (Expanded Programme on Immunization) for the whole district with one fixed centre and two outreach and mobile teams. Tdh also implements Polio and Measles Mortality Reduction Campaigns together with WHO and UNICEF.
- iii. Nutrition programme; including assessment of childhood malnutrition by using international indicators like Weight for Height, supplementary feeding programme for children, pregnant and lactating mothers and prevention and treatment of Micronutrients deficiency diseases.
- iv. Health Education; including the training of CHWs (community Health Workers), CHV (community health volunteers) and providing health education in the clinics and schools through the professional and trained Health Educators.
- v. Tuberculosis Control programme; which is started recently with the help of WHO.

13. Analysis of significant facts:

- a) Discrimination: Women's discrimination in Afghanistan has to be seen as a mechanism of male control over women's movements and participation. If half of the adult population is excluded from public life, competition is less rough.⁷ Restriction of movement and limited mobility as well as lack of exposure and participation prevents many women in Afghanistan to access health facilities and health programs. They are left alone with their health problems and with their little knowledge about nutrition.
- b) Seclusion: The seclusion of women, called purdah, is one important component of the honor code; honor and honorable behavior being the most desired status symbol of Afghan society. Purdah (seclusion of women) implies submission, respect and abnegation. In its strictest form it involves the isolation of the woman within the compound and precludes her from any form of contact with men other than her husband, father, brothers, mother's brothers and maternal male cousins. Women's seclusion was not simply a matter of rights, but of status – and status was always closely linked to education. Purdah cannot be enforced without the cooperation of men. Boys are taught by both their mothers and fathers to respect the seclusion of women. Purdah is regarded as a safeguard for women against physical attacks from men who are not related to them. It is considered as a kind of protection for threatened communities against a dangerous and unpredictable world, which safeguards the security and privacy of the women.⁸ Seclusion of women therefore considerably attributes to isolation and feelings of loneliness, which significantly contributes to lack of care for women themselves and especially for their children – with very negative impacts on nutritional status. A recurring observation in most families visited is the loneliness and isolation of mothers.
- c) The fear of men: It seems that the macho comradeship among Afghan men is de facto based on a hidden fear of women, which is linked to the lack of capability to deal with sexuality and emotions. The long-lasting war by further militarizing the Afghan society has increased this tendency: Survival consisted in fighting, and women were not allowed to fight. Therefore, the value of women further decreased.⁹
- d) Attitudes about women: Probably the most difficult aspect of Afghan society is the attitude towards women. They are the source of all honor and continuity. They must be kept secure and chaste, so that the lineage itself remains pure. Her family is obligated to avenge any real or perceived threat to this honor. All ethnic groups feel obliged to shield women from contact with outsiders to guard against dishonor or even gossip which would threaten the family and call for violence or revenge. This behavior and deeply-rooted cultural belief presents serious constraints to health service providers, because women's health remains partly inaccessible for health service providers vice versa.

⁷ *Terre des hommes in Afghanistan: The Capitalisation Report: Gender; 2002*

⁸ *ibidem*

⁹ *ibidem*

- e) Domestic violence: “From the time of marriage, the girl is treated in the same way as older women in the family and it is not uncommon for intercourse to take place with the husband before puberty where girls are married very young. Once married, many women and girls accept beating and domestic violence as a part of life, with the widespread belief among both men and women that it is a man's "right" to discipline his wife where she is felt to have disobeyed or misbehaved. She may also be beaten if she bears no children or no sons, with this also cited as one of the main reasons for men to take a second wife. Threats, verbal and physical abuse are more likely if the husband is unhappy about the marriage arranged by his parents, with this especially common where the girl or woman is an "exchange bride" or widow forced to re-marry within the family.”¹⁰ Domestic violence creates not only deep frustration but also aggression and depression. The mother at risk may target herself or her child, or more often will be unable to provide proper care.

14. Lessons learnt

- a) Whereas most health education programs are targeting women through health practitioners in clinic settings where time is limited and women less likely to be receptive, the programs of *Terre des hommes* in Kabul and Kandahar focus on home visits and health education in neighborhoods where women are more receptive due to a more relaxed and familiar atmosphere.
- b) The impact of health education remains with the difficult-to-measure changes in behavior. Methods of measuring success, particularly among children, suggest that health education sessions where adolescent girls participate may have a significant impact on Afghan girls, promoting their status in the family and raising their own self-esteem. More attention is needed to provision of health education for children and adolescents, and these groups should be appropriately targeted wherever provision is made for health education of adults.
- c) More attention must be given to methods of measuring direct and particularly indirect impact of health education on children and adolescents. In addition indirect impact should not be neglected as a potentially important result of health education.
- d) The Rustaq health program has made significant impact in terms of preventative services by focusing on immunization, diarrhoeal diseases and respiratory infections, water and sanitation.
- e) Lack or shortage of food is not the only cause of malnutrition, since malnutrition is a multi-factor problem e.g. psychosocial causes, dysfunctional families or lack of knowledge to use the existing resources.
- f) BP-5 is not the real solution for malnutrition and use of locally available foods have a better contribution in treatment and prevention of malnutrition.

¹⁰ Lost Chances - The changing situation of children in Afghanistan, 1990-2000

- g) Formation of Community Based Organizations (CBOs) is useful in community empowerment and its active participation. The CHWs are selected from the community; this action has vital importance for the sustainability of the project, as the CHWs know all good and bad habits of their people and the people trust them.
- h) In the beginning of Rustaq Nutrition Project Component, the international standards and indicators were not used, and malnutrition was diagnosed clinically by the doctors, BUT now the international indicators (MUAC, W/H, Edema) are used for the nutritional assessment.
- i) In the beginning the exclusive breastfeeding of 4-6 months has been promoted in Kabul, but as a result of new development and coordination with international organizations (WHO, UNICEF etc) 6 months are now promoted.
- j) The community health program has changed from a clinical approach to a family or community approach. As a result service provision is not anymore the sole intervention strategy, but a listening approach is applied together with efforts and measures to increase mothers' solidarity.
- k) The underlying causes of malnutrition should be addressed and projects like micro-finance and kitchen gardening etc should start with the help of other organizations in order to improve the nutritional status of the populations in a sustainable way.
- l) For the effectiveness of health education, it is better to first listen to the mothers and find out the problem and then provide related health education.
- m) The results of family planning proved its important role for better nutrition of mothers and children. Knowledge about and promotion of birth spacing and awareness about adverse affects of frequent pregnancies contribute visibly to a better nutritional and health status of women. The project also made efforts, partly successfully, to target men as well with family planning information and services, in order to influence male attitudes.

13th December

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