



AGA KHAN FOUNDATION  
AFGHANISTAN

2015

# Health and Nutrition Survey



Aga Khan Foundation, Afghanistan

2015



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## List of Abbreviations

AHNS	Afghanistan Health & Nutrition Survey AKDN Aga Khan Development Network
AKF	Aga Khan Foundation
ANC	Antenatal Care
APHI	Afghanistan Public Health Institute
ASFR	Age Specific Fertility Rate
BCG	Bacilli Calmete Guerin
CAHSS	Central Asia Health System Strengthening
CBR	Crude Birth Rate
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
C-Section	Cesarean Section
CSO	Central Statistic Office
DHS	Demographic Health Survey
EA	Enumeration Area
ECD	Early Childhood Development
EPI	Expanded Program of Immunization
GFR	General Fertility Rate
HiB	Homophiles Influenza Type B
IUD	Intra Uterine Device
IYCF	Infants and Young Child Feeding
MOPH	Ministry Of Public Health
NNS	National Nutrition Survey
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PNC	Postnatal Care
RHF	Recommended Homemade Fluid
TFR	Total Fertility Rate

UNICEF United Nation International Children's Emergency Fund  
VAD Vitamin A Deficiency  
WHO World Health Organization

## **CONTRIBUTORS**

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Afghan Center for Socio-economic and Opinion Research

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Sincerely

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## 1.1 Background

The Afghanistan Health and Nutrition Baseline Survey (AHNS) was conducted as part of the Central Asia Health Systems Strengthening Project (CAHSS), a multi-year initiative being implemented in selected areas in Afghanistan, Pakistan, Tajikistan and the Kyrgyz Republic with funding from the Aga Khan Foundation Canada. CAHSS was developed to respond to the critical, persistent, and emerging health needs of the population, and in particular women, newborns and children under five. The Aga Khan Development Network (AKDN) has adopted an approach to ensure essential service availability in a system that will become less reliant on external actors, such as donors. This five-year initiative was developed in the context of AKDN's long-term presence, indigenous recognition and extensive familiarity in the region. This project seeks to coordinate, align, expand and enrich the current activities of the various AKDN agencies in the region, in close collaboration with the local, provincial and national governments. The project is fully aligned with the health sector policies and strategies of all four countries.

As part of the CAHSS project, baseline surveys were planned to be carried in the project areas in each of the four countries, namely, the remote areas of northern Afghanistan, eastern Tajikistan, central and southern Kyrgyz Republic, and northern Pakistan. These areas share many common traditions and challenges to improving the wellbeing of the populations. Owing to their physical isolation, communities in these areas are often the poorest within their countries; they are marginalized from national social, economic, and political developments, and have experienced perpetual under-investment in the health sector. The needs of these areas can be better understood and addressed by viewing them as a sub-region, where economies of scale for health systems across national, but contiguous, boundaries can be achieved.

Aga Khan Foundation-Afghanistan's (AKF,A's) health program renders health services—both health care services (particularly the Basic Package of Health Services for lower-tier health facilities and the Essential Package of Health Services for provincial, regional, and tertiary hospitals) and also health promotion interventions—in the central and northeast part of the country. The regions cover the provinces of Badakhshan, Takhar, Baghlan and Bamyan. Most of these areas are located within the Hindu-Kush mountain terrain and because of the geographical harshness these communities are segregated from the rest of the country. Access to some of these communities is very difficult and still requires the use of traditional types of transportation (e.g., animals), which deprives them from access to many health and educational services.

Another barrier to access to social services is confining gender norms, which can restrict access to health information and services, though the extent differs from one village to the next. The effect of these gender norms includes significant challenges to accessing health care and nutrition services, and information on measures to promote health and prevent illness. Critically, in a country with one of the highest maternal mortality rates in the world, emergency care is often inaccessible because of cost of travel outside of the village and the requirement for a male family member as chaperone. Often, men do not consult women in household decisions on health matters and women's and men's health-related knowledge, attitudes and behaviors are frequently ill-informed.

According to the National Risk and Vulnerability Survey 2011-12, only 31 percent of adult men and women in Afghanistan are literate (45 percent of men and 17 percent of women). The proportion of

adults age 25 and over who completed at least primary school is 18 percent, while those who completed secondary comprise 9 percent and those who completed university are only 2 percent (CSO, 2014).

Health indicators in the country are ranking lowest in the region (UNICEF, 2015), but the situation is far worse in these mountainous areas (Kanji et al., 2012). The maternal mortality ratio in rural areas of the country is around 417 pregnancy-related deaths per 100,000 live births (APHI et al., 2010). The northern areas of the country also experience relatively high maternal mortality (354 per 100,000 births), so the combination of rural, northern areas would presumably be subject to very high mortality (APHI et al., 2010). Child mortality is another indicator which shows drastic figures. The under-five mortality rate is 91 per 1,000 births and the infant mortality rate is 48 per 1,000 births (CSO, 2014).

Drought and lack of fertile agriculture land, along with utilization of traditional farming tools has reduced agricultural productivity in the program areas. Consequently, the communities do not have access to enough food and malnutrition is common; the proportion of children under five who are underweight (i.e., weight-for-age below -2SD) is 25 percent at the national level (MOPH and UNICEF, 2014), and the figures in the program provinces of Badakhshan, Bamyan and Takhar are even higher than the national figures: 33 percent, 25 percent, and 28 percent, respectively (MOPH and UNICEF, 2014). Stunting among children under five years of age is estimated at 52 percent of children in Bamyan, 50 percent in Badakhshan, and 47 percent in Takhar, all higher than the national average of 41 percent; only Baghlan province (37 percent) is lower than average (MOPH and UNICEF, 2014).

An exclusively breastfeeding infant for six months is globally regarded as the best for optimum development of the child. At the national level, 58 percent of children under six months are being exclusive breastfed, while this practice is more widespread in the provinces of Badakhshan (81 percent), Baghlan (73 percent), Bamyan (83 percent), and Takhar (93 percent) (MOPH and UNICEF, 2014).

Immunization of children during their first year of life is crucial and protects children from getting major killer diseases. The coverage rate for the third dose of pentavalent vaccine among children age 12-23 months is globally accepted as an indicator to measure immunization status. This indicator is 65 percent in Badakhshan, 74 percent in Baghlan, 84 percent in Bamyan, and 74 percent in Takhar (GDPM et al. 2014).

Two useful indicators of child morbidity are the prevalence of acute respiratory tract infections (ARI) and the prevalence of diarrheal disease during the two weeks before the survey among children under five. The prevalence of ARI is 8 percent in Badakhshan, 41 percent in Baghlan, 18 percent in Bamyan, and less than 1 percent in Takhar, while the prevalence of diarrhea is 59 percent, 23 percent, 43 percent, and 25 percent, respectively (MOPH and UNICEF, 2014).

For antenatal care, prior data show that 16 percent of pregnant women received care from a skilled provider in Badakhshan province, while in Baghlan, the indicator was 37 percent, in Bamyan 73 percent and in Takhar 34 percent (MOPH and UNICEF, 2014). Pregnant women who received at least two antenatal visits are 6 percent, 13 percent, 14 percent and 12 percent, respectively.

Skilled birth attendance (i.e., the proportion of women receiving assistance from any trained health professional during delivery) is 13 percent in Badakhshan, 35 percent in Baghlan, 48 percent in Bamyan, and 28 percent in Takhar (MOPH and UNICEF, 2014).

## **1.2 Objectives of the Survey**

The key objectives of the Health and Nutrition Survey (HNS) were to establish baseline data on demographic indicators, literacy and education, child and maternal health indicators, and early childhood development in the program areas. The cross-sectional community level survey was planned to be carried out in all districts where AKF Afghanistan health programs were actively engaged. This survey will serve

as a baseline for health program indicators and improvement will be measured with another survey of the same kind after five years.

Specific objectives of this survey were:

- To measure the key demographic indicators, particularly fertility and under-five mortality rates
- To measure the level of contraceptive knowledge and practice
- To explore key aspects of family health, including immunization coverage, child morbidity and maternal health care indicators, e.g., antenatal visits and assistance at delivery
- To assess current child feeding practices including breastfeeding and to collect anthropometric measures (height and weight) to assess the nutritional status of women and children under age five.

### 1.3 Organization of the Survey

The AHNS was conducted by the Aga Khan Foundation Afghanistan (AKF,A) with financial support of AKF Canada (AKFC) and the Department of Foreign Affairs, Trade and Development. ICF International provided technical assistance through a contract with the AKFC. Such assistance consisted mainly of presenting workshops on questionnaire and survey design, data entry, and data tabulation, as well as providing a local consultant to assist during the training of field staff. Additional assistance consisted of advice on sample design and implementation, calculation of sample weights, assistance with production of tabulations, and assistance on report writing. The Central Statistics Organization (CSO) Afghanistan selected the enumeration areas and also provided the maps for the sampled areas. AKF Afghanistan hired a consulting firm (ACSOR/D3) for field staff recruitment and training, data collection, and data management. This report was generated by AKF Afghanistan with the assistance of ICF.

### 1.4 Sample Design

Based on a careful consideration of both the desired indicators to be measured in the survey and budgetary constraints, ICF recommended that the survey utilize a sample size of 1,200 households to be selected in 40 sample points (clusters). This design would allow an acceptable level of precision to be achieved for most of the target indicators and moderate change to be detected between the baseline survey and an end-line survey expected to be implemented approximately five years after the baseline.

The AHNS was carried out using a two-stage cluster sampling approach. The sampling frame used for the 2014 AHNS was the Household Listing Frame prepared in 2003-2004 and updated in 2009 by the CSO. The frame consists of a list of geographical enumeration areas (EAs). In rural areas, an EA is usually either a natural village, a part of a large village, or a group of small villages; in urban areas, an EA is usually a city block. Each EA has a measure of size which is the number of households residing in the EA, as well as a map which defines its geographical boundaries. In the first stage, the CSO selected 40 EAs (clusters) with probability proportional to size from the master frame in the following 31 districts of four provinces:

1. **Badakhshan:** Baharak, Darwaz Bala (Nusai), Darwaz (Maimai), Ishkashim, Jurm, Khash, Kufab, Kishm, Shukai, Shughnan, Wakhan, Yomgan, Zebak, Warduj and Shuhada
2. **Baghlan:** Dushi, Dahn-e-Ghori, Khinjan and Pul-e-Khumri,
3. **Bamyan:** Bamyan center, Saighan, Kahmard, Shiber, Yakawlang, Panjab and Waras
4. **Takhar:** Warsaj, Kalafgan, Rustaq, Dashti Qala and Baharak



Maps were provided by the CSO for each of the selected areas. ACSOR estimated the number of households for each EA/village and evaluated each based on accessibility, transportation, and weather, creating a separate Excel file with the evaluation for each village (available upon request).

The household listing operation consisted of a team of three “cartographers” who carried out the listing operation in each EA just prior to the start of interviewing in the EA. Listing consisted of marking the doors for each household; if there were several households in one dwelling, each was counted as a separate household. The starting point, e.g., a mosque or other prominent place, and the end point were mapped and photos were taken in the selected EAs/clusters and of the marked doors of houses. However, to ease the logistical burden, in large EAs with multiple villages, the supervisor selected certain villages. Teams started with one village and enumerated up to 200 households; if a second or third village was needed to achieve 200 households, then the teams moved clockwise from village to village.

After completing the listing activity, the listings served as the sample frame for household selection. In this second stage of selection, a fixed number of 30 households per enumeration area were selected randomly from the newly created household listings. The households were selected by the supervisor using the random number generator application on an Android phone. The selected households were circled on the listing sheet.

The survey interviewers were to interview only these selected households. No replacements or changes of the pre-selected households were allowed, in order to prevent bias. Three contact attempts were required for each household before considering the unit as non-response.

Of the 40 EAs/clusters, four were inaccessible due to security concerns: one each in Jurm, Kishm, and Wardooj in Badakhshan, and Kahmard in Bamyān. A fifth EA in Darwaz-e-Bala district in Badakhshan Province was inaccessible due to weather. Because of this and because of the non-proportional sample sizes in each province, weighting factors have been added to the data file so

### Definitions

A structure is a free-standing structure that can have one or more dwelling units for residential or commercial use. Residential structures can have one or more dwelling units (for example: single house, apartment structure).

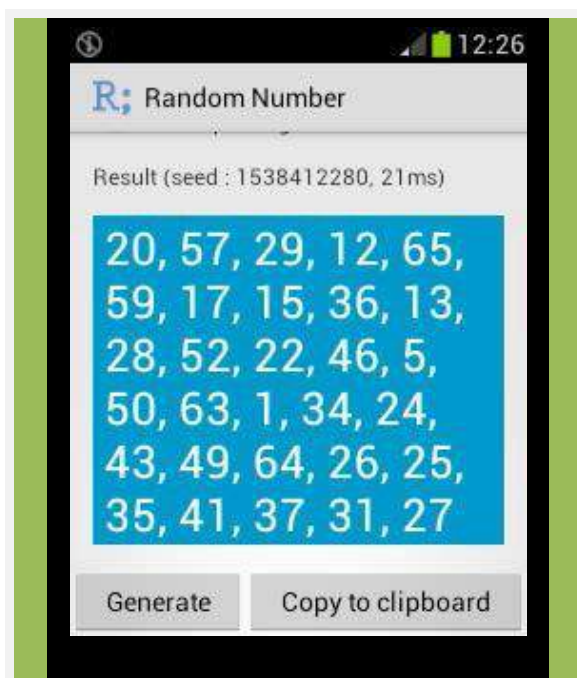
A dwelling unit is a room or group of rooms normally intended as a residence for one household (for example: a single house, an apartment, a group of rooms in a house); a dwelling unit can also have more than one household.

A household consists of a person or a group of related or unrelated persons, who live together in the same dwelling unit, who acknowledge one adult male or female 15 years old or older as the head of the household, who share the same housekeeping arrangements, and are considered as one unit. In some cases one may find a group of people living together in the same house, but each person has separate eating arrangements; they should be counted as separate one-person households.

The head of household is the person who is acknowledged as such by members of the household and who is usually responsible for the upkeep and maintenance of the household.

The following three conditions are tests for determining if a group of persons consists a single household or multiple households: if all the three conditions below hold, it relates to a single household; if one of the conditions below does not hold, it relates to multiple households.

1. Persons reside in the same structure most of the time
2. Persons acknowledge the same household head
3. Persons share the same cooking/housekeeping arrangement



that the results will be representative for the entire target area.

All ever-married women age 15-49 who were either permanent residents of the selected households or visitors who stayed in the household the night before the survey were eligible to be interviewed.

## **1.5 Questionnaires**

Two questionnaires were used for the AHNS: the Household Questionnaire and the Ever-Married Woman's Questionnaire. These questionnaires were based on core questionnaires developed for use by all four countries involved in the CAHSS program during a workshop held in Kyrgyzstan from 9-20 June 2014. These core questionnaires were in turn based on standard survey questionnaires developed by the Demographic and Health Surveys (DHS) program ([www.dhsprogram.com](http://www.dhsprogram.com)).

The core questionnaires were adapted to the local context in Afghanistan. The testing of sensitive questionnaire items revealed some items that needed to be modified. Items on abortion and certain items on contraceptive methods were modified due to cultural sensitivities in Afghanistan. For example, the question: "In the past three years, have you had an abortion" was removed. However, items related to stillbirths or miscarriages remained in the questionnaire. Special training was given on the sensitive items regarding the use of contraceptive items. Female interviewers were required to read aloud the types of contraceptives. However, interviewers were trained to pay special attention to the environment, comfort levels, and privacy of women when answering these items. Interviewers were only allowed to write "refused" if there were concerns related to the woman's safety. Once the questionnaires were finalized in English, they were translated into Dari.

The Household Questionnaire was used to list all the usual members of and visitors to selected households. Some basic demographic information was collected on the characteristics of each person listed, including his or her age, sex, education, and relationship to the head of the household. For children under age 18, survival status of the parents was determined. The data on age, sex, and marital status of household members obtained in the Household Questionnaire were used to identify women who were eligible for individual interview and children under five years who were eligible for the questions about early childhood development. The Household Questionnaire also collected information on characteristics of the household's dwelling unit, such as the source of water, type of toilet facility, ownership of various durable goods, and observation by the interviewer of the toilet, hand washing location, place of salt storage, etc.

The Ever-Married Woman's Questionnaire was used to collect information from all women age 15-49 listed in the household who were either currently married or widowed, divorced, or separated. Ever-married women who consented to being interviewed were asked questions on the following topics:

- Background characteristics (age, education, literacy, marital status, etc.)
- Birth history and child mortality
- Knowledge and use of family planning methods
- Fertility preferences
- Antenatal, delivery, and postnatal care
- Breastfeeding and infant feeding practices
- Childhood vaccinations
- Other health issues (e.g. smoking, chronic diseases)

## **1.6 Training of Field Staff**

Multiple fieldwork-related training sessions and workshops were conducted in preparation for this study, including:

1. Questionnaire Training (4 days)
2. Pretest of Questionnaire for Sensitive Items (1 week)
3. Fieldwork Training Workshop (5 days) - All interviewers + Supervisors
4. Supervisor Fieldwork Sampling Workshop (4 days) - Supervisors
5. Pretest Fieldwork, Debriefing (2 days) - All interviewers + Supervisors

A total of 45 interviewers took part in this project. Interviewers worked in groups of three. Each team included one male supervisor and two female interviewers. The supervisor had an active role during field and was present in the enumeration area for the entire time, overseeing the listing operation, interviewing, and implementing quality control.

All field interviewers and supervisors were required to attend a 5-day Fieldwork Training Workshop in Kabul from 12-16 October 2014. Representatives from Aga Khan Foundation and the ICF local consultant were present at parts of the workshop. A full Training and Fieldwork Manual was developed for this purpose and is available for those who are interested in more details and instructions on all filters, listing requirements, and procedures for collecting anthropometric measurements.

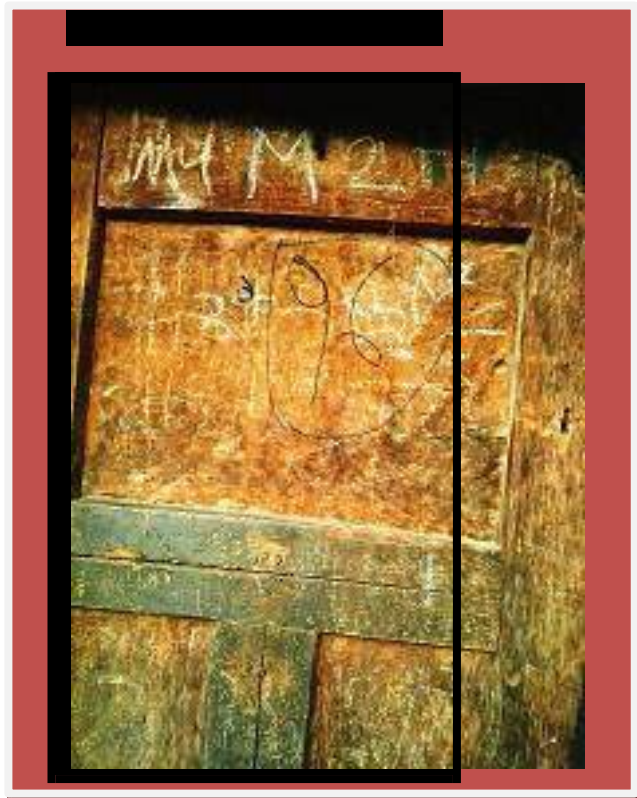
The topics covered in the workshop were:

- Introduction to the HNS Survey
- Responsibilities of the supervisors
- Line-by-line review of the Household and Woman's questionnaires
- Height and weight lecture, demonstration, and practice
- Early childhood development
- Review of eligibility and line number
- Birth history and sensitive items
- Child immunization records (with example card)
- Sampling and enumeration
- Mock interviews between trainees for practice

On the last day of the workshop, a pretest was conducted in Kabul for at least 10 households. A full-team debriefing was conducted at the end of the pre-test.

## 1.7 Fieldwork

After completion of training in Kabul, the teams went back to their respected provinces and commenced fieldwork. Teams had a list of the selected EAs in their provinces, so before initiating actual



data collection in each EA, a separate team of “cartographers” mapped and listed all the households in the EA, and marked the doors of households. Later on, using these lists, the households to be interviewed were randomly selected with no replacement and interviews were conducted with eligible participants. If interviewers were not able to find a suitable respondent to interview in a selected household on the first visit, they were required to make two call-backs before categorizing the household as a non-response.

To assure the quality of interviews, a minimum of 5 percent of households were back-checked via direct observation by the supervisor and 10 percent were revisited by the supervisory team. In the return visit, the supervisor or someone from his control team returned to the residence where the interview took place, typically on the same day of the interview. If a household failed the back-check, the household was to be re-surveyed by the original interviewers with someone from the supervisory team present during the entire interview.

Supervisors were required to observe fieldwork and check for the following issues:

- That the correct household was interviewed based on the listing and randomized selection
- That only female interviewers were conducting the women’s questionnaire and that no male household members are present
- That the field team was carrying the Training and Fieldwork Manual
- That teams had an adequate number of questionnaires and additional lists for large households
- That 3 contact attempts were made for each household
- That all eligible women were interviewed and that all eligible children were measured
- That all 30 households selected were completed and that the enumeration area was completed and recorded properly
- That household and women’s questionnaires were arranged and packaged properly and were labeled by sampling point number and household number
- That all the contents of the household questionnaire were checked before proceeding to the next household
- That all line numbers were recorded and transferred properly, that all birth history numbers were recorded and transferred properly
- That all dates of birth and ages were accurately calculated

Supervisors were also responsible for ensuring that all the specified materials, resources, and supplies as listed in the Training and Fieldwork Manual, were available for the field teams. Supervisors were also given a checklist prior to sending the packs of completed questionnaires back to the central office in Kabul.

AKFA made arrangements to conduct third party monitoring of the interviewing teams. The requirements for observation included checking the enumeration area for the selection of 30 randomized households. Furthermore, monitors visited at least five households per cluster, checking for markings on doors, corroborating the number of eligible children and women in households, checking for some key questions in the questionnaires, e.g., the number of children who died, and checking whether all children eligible for anthropometry were measured for height and weight. Data collection started on 25 October 2014 and was completed by 13 December 2014.

## 1.8 Data Processing

Data entry and data processing was conducted in CSPro. The data entry application was programmed to systematically verify birthdates, data ranges, logic of skips in the questionnaire, and internal consistency of the data.

The data entry team consisted of 1 CSPro specialist, 1 CSPro supervisor, and 10 data entry clerks. Amongst the data entry clerks, a household specialist and a woman's specialist were identified to oversee entry of these questionnaires. The data entry team was required to participate in a CSPro Data Entry Workshop and Pretest Data Entry prior to being approved to work on the main survey. The entire data entry team was trained on CSPro applications and operating procedures.

Prior to fieldwork and logistics planning, the data entry supervisor attended the CSPro Data Entry and Editing Workshop for all four CAHSS countries in Istanbul, Turkey organized by ICF International. The goals of the workshop were to learn the mechanics of CSPro and create the data entry application. The remaining country-specific changes and modifications during data entry and fieldwork were the responsibility of the Afghanistan CSPro specialist.

Once the questionnaire packs were received from field, they were processed one province at a time. When the questionnaire packs returned from field, each questionnaire was checked for completeness and logic. Following is a description of the steps taken to process the primary data.

- Step 1: Primary data were entered using the application programmed under AKF and ICF guidance at the Istanbul workshop. All procedures, logic checks, and quality control procedures developed.
- Step 2: Upon completion of the primary data entry, all error messages were reviewed by the data entry supervisor.
- Step 3: Hard copy questionnaires were reviewed to determine the type of error. If it was a data entry error, the primary data were corrected; if it was a logic error, the project manager and field supervisors were consulted to determine the correct response. The primary data were corrected to reflect the validated data from the household and women's interviews.
- Step 4: Upon completion of the primary data entry for the entire sampling point by the workstation key puncher, the key puncher supervisor reviewed each questionnaire's content, logic, and checks for key punching errors against the hard-copy questionnaires. This was the verification procedure.
- Step 5: When a sampling point's data entry was complete, the data entry specialist reviewed the entire province's data file for pending errors. The data entry specialist then checked again the hard copy questionnaires for the valid response. If there was an error, the workstation data entry clerk reentered the data and steps 1-5 were repeated.
- Step 6: Field project managers then verified the final household compositions and number of completed interviews with the enumeration data, as reported by the field teams. Any inconsistencies required a repeat of steps 1-6.
- Step 7: Once the data were completely verified, the data entry specialist and project manager denoted the household questionnaire as final and dated the file in CSPro.
- Step 8: Any additional findings, based on the secondary editing were reviewed for a 1 month period. Topics included date of birth and age differences, height and weight outliers, and vaccination dates.

All data from the questionnaires were entered twice (100 percent verification or double entry) by the data entry team. All error logs were reviewed, consistency comparisons between primary and secondary were resolved, and correction sheets were created prior to finalizing the data.

Secondary data editing and recoding for the following topics were also reviewed and verified as accurate by the data entry team: household listing and relationships within household, birth history listings by mothers, dates of birth, other dates reported by respondents, age reported by respondents, and vaccination dates.

Data entry was initiated in mid-November 2014 and completed on 29 January 2015. Initial tabulations were produced on a partial dataset during the data analysis and tabulation workshop conducted in Islamabad, Pakistan from 1-14 December 2014. Additional cleaning and checking of the complete dataset and calculation of the sample weights took place during February-March. Final tabulations were produced by the ICF data processing consultant in April-May 2015.

## 1.9 Response Rates

Table 1.1 shows response rates for the 2014 AHNS. A total of 1,050 households were selected for the sample, of which 1,020 were occupied. Of the occupied households, 1,002 were successfully interviewed, yielding a response rate of 98 percent. In the interviewed households, 1,009 ever-married women age 15-49 were identified for individual interview; of these, complete interviews were conducted with 979 women, yielding a response rate of 97 percent.

**Table 1.1 Results of the household and individual interviews**

Number of households, number of interviews, and response rates, according to residence (unweighted), Afghanistan 2014

Result	Total
<b>Household interviews</b>	
Households selected	1,050
Households occupied	1,020
Households interviewed	1,002
Household response rate <sup>1</sup>	98.2
<b>Interviews with ever-married women age 15-49</b>	
Number of eligible women	1,009
Number of eligible women interviewed	979
Eligible women response rate <sup>2</sup>	97.0

<sup>1</sup> Households interviewed/households occupied

<sup>2</sup> Respondents interviewed/eligible respondents

## Key Findings

- 55 percent of households in the program areas use an improved source of drinking water and one-quarter of households boil water before drinking.
- 3 in ten households use improved toilet facilities that are not shared with other households, mostly pit latrines with slabs.
- 79 percent of households have access to electricity.
- 4 in ten households reported having a television and 80 percent have a mobile telephone; only 4 percent are connected to the internet.
- More than 9 in 10 children under 18 are living with both their natural parents. Fostering is not common; less than one percent of children are not living with either of their biological parents even though both are still alive.
- 5 percent of children under age 18 are orphaned (that is, one or both parents are not living).
- Education levels are low; less than half of women and men age 6 and over have ever attended school. However, among children age 9-11, attendance rates are close to 80 percent.

This chapter presents information on demographic and socioeconomic characteristics of the household population such as age, sex, and education. The environmental profile of households in the 2014 Afghanistan Health and Nutrition Survey (AHNS) sample is also examined. Taken together, these descriptive data provide context for the interpretation of demographic and health indices and can furnish an approximate indication of the representativeness of the survey.

In the AHNS, a household was defined as a person or group of related and unrelated persons who lived together in the same dwelling unit(s), who acknowledged one adult male or female as the head of the household, who shared the same housekeeping arrangements, and who were considered a single unit. For each household, information was obtained on usual household members as well as visitors present in the household on the night before the survey. The de jure population includes all usual household residents whether or not they were present at the time of the AHNS interview. The de facto population represents all those who stayed in the selected household the night before the interview, whether they were usual residents or visitors. The difference between the de jure and de facto populations is small, and most results are presented for the de facto population unless otherwise noted.

## 2.1 Household Characteristics

The physical characteristics of households and the availability and accessibility of basic household facilities are important in assessing the general welfare and socioeconomic condition of the population. The 2014 AHNS collected information on a range of housing characteristics, including source of drinking water, water treatment, type of sanitation facility, access to electricity, type of cooking fuel, and frequency of consumption of meat and fruits and vegetables. In addition, interviewers were asked to observe the place where household members most often wash their hands, the place where salt and water are stored, and the toilet.

### 2.1.1 Drinking Water

Table 2.1 includes indicators that are measure household access to improved drinking water. Improved sources of drinking water are those which are more likely to protect water from contamination. These sources include piped water within the dwelling, yard, or plot; a public tap; a protected well or borehole; and a protected spring.<sup>1</sup> Other sources such as unprotected wells, rivers or streams, and ponds, lakes, or dams are considered unimproved because these sources are open to fecal contamination and could cause waterborne diseases and diarrhea. The distance to fetch drinking water is another indicator which can affect availability. Even if the water is obtained from an improved source, it may be contaminated during transport or storage. Finally, home water treatment can be effective in improving the quality of household drinking water.

Results indicate that just over half of the households (55 percent) in the survey areas have access to improved water sources: 11 percent from water piped into the dwelling or plot, 20 percent from a public tap or standpipe, and 23 percent from a tube well, protected well or spring. Compared with results for the whole country from the 2013 National Nutrition Survey (NNS), the CAHSS surveyed areas show a lower proportion of households with improved sources of drinking water (55 versus 63 percent)(MOPH and UNICEF, 2014).

Forty-four percent of households get drinking water from an unimproved source; 28 percent fetch their drinking water from unprotected springs and 16 percent from unprotected wells.

With regard to the distance to water sources, 27 percent of households have water on their premises, while 62 percent are within 30 minutes roundtrip of their drinking water source and 12 percent of households take more than 30 minutes to go, get water and return home.

Households were asked about treating of drinking water to make it safe for drinking. Overall, one-quarter of households boil their drinking water and 5 percent use bleach or chlorine to disinfect the water. Only 2 percent of households were using solar disinfection.

**Table 2.1 Household drinking water**

Percent distribution of households and de jure population by source of drinking water, time to obtain drinking water, and treatment of drinking water, Afghanistan 2014

Characteristic	Households	Population
<b>Source of drinking water</b>		
<b>Improved source</b>	<b>54.8</b>	<b>54.5</b>
Piped into dwelling	1.0	1.0
Piped to yard/plot	9.9	9.5
Public tap/standpipe	20.4	19.4
Tube well or borehole	10.3	9.1
Protected well	11.0	13.3
Protected spring	2.0	2.0
Rain water	0.1	0.2
<b>Non-improved source</b>	<b>43.9</b>	<b>44.2</b>
Unprotected well	15.6	16.5
Unprotected spring	28.0	27.4
Tanker truck/cart with drum	0.3	0.3
Other	1.3	1.3
<b>Total</b>	<b>100.0</b>	<b>100.0</b>
<b>Time to obtain drinking water (round trip)</b>		
Water on premises	26.5	27.6
Less than 30 minutes	61.6	61.6
30 minutes or longer	11.8	10.7
Don't know/missing	0.1	0.1
<b>Total</b>	<b>100.0</b>	<b>100.0</b>
<b>Water treatment prior to drinking<sup>1</sup></b>		
Boiled	26.0	26.2
Bleach/chlorine added	5.1	5.8
Strained through cloth	0.6	0.5
Solar disinfection	1.8	1.6
Other	2.2	1.6
No treatment	65.5	65.5
Percentage using an appropriate treatment method <sup>2</sup>	28.6	29.0
Number	1,002	6,815

<sup>1</sup> Respondents may report multiple treatment methods so the sum of treatment may exceed 100 percent.

<sup>2</sup> Appropriate water treatment methods include boiling, bleaching, filtering, and solar disinfecting.

<sup>1</sup> The categorization into improved and non-improved categories follows that proposed by the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (WHO and UNICEF, 2012b).



## 2.1.2 Sanitation Facilities and Waste Disposal

Use of improved sanitation facilities by households is associated with reduction in diarrheal diseases and improved nutrition status. Households were classified as having an improved sanitation facility if the facility was used only by members of one household (i.e., it is not shared) and if the facility separates the waste from human contact (WHO and UNICEF, 2012a). The types of facilities considered improved are toilets that flush or pour flush into a piped sewer system, septic tank, or pit latrine; ventilated improved pit (VIP) latrines; and pit latrines with a slab.

Table 2.2 shows that 30 percent of the households in the survey areas were using improved sanitation facilities that are not shared with other households, mostly pit latrines with slabs (20 percent), VIP latrines (8 percent) and toilets that flush to a sewer system, septic tank, or pit (2 percent). The proportion of households with improved sanitation facilities is much lower than the national level of 40 percent (MOHP and UNICEF, 2014).

Twelve percent of households use sanitation facilities which are shared among two or more households, mostly pit latrines with slabs. Unimproved sanitation facilities are used by 59 percent of households, with 32 percent of households having no facility except bushes and fields, while 19 percent use a pit latrine without a slab and 6 percent use buckets.

Table 3\_2.2 Household sanitation facilities

Percent distribution of households and de jure population by type of toilet/latrine facilities, Afghanistan 2014

Type of toilet/latrine facility	Households	Population
<b>Improved, not shared facility</b>		
Flush/pour flush to piped sewer system	0.1	0.2
Flush/pour flush to septic tank	1.1	1.0
Flush/pour flush to pit latrine	0.3	0.2
Ventilated improved pit (VIP) latrine	8.0	9.0
Pit latrine with slab	20.0	22.1
Total	29.5	32.6
<b>Shared facility<sup>1</sup></b>		
Flush/pour flush to piped sewer system	0.2	0.2
Flush/pour flush to septic tank	0.7	0.9
Flush/pour flush to pit latrine	0.3	0.3
Ventilated improved pit (VIP) latrine	1.9	1.2
Pit latrine with slab	8.7	7.1
Composting toilet	0.3	0.2
Total	11.9	9.8
<b>Non-improved facility</b>		
Flush/pour flush not to sewer/septic tank/pit latrine	0.6	0.5
Pit latrine without slab/open pit	19.3	19.9
Bucket	6.2	6.0
Hanging toilet/hanging latrine	0.8	1.0
No facility/bush/field	31.7	30.2
Total	58.6	57.6
Total	100.0	100.0
Number	1,002	6,815

<sup>1</sup> Facilities that would be considered improved if they were not shared by two or more households.

### 2.1.3 Housing Characteristics

Table 2.3 presents information on characteristics of the dwelling in which households live. In addition to reflecting the household's socioeconomic situation, these characteristics show environmental conditions in which the household lives. For example, use of biomass fuels exposes the household members to indoor pollution, which has a direct bearing on their health and welfare.

Use of electricity usually goes hand in hand with improved housing structures and a better standard of living. In the survey areas, 79 percent of the households have electricity.

Cooking and heating with solid fuels can lead to high levels of indoor smoke, a complex mix of health-damaging pollutants that can increase the risk of contracting diseases (WHO, 2011a). Solid fuels include charcoal, wood, and agricultural crops. In the AHNS, households were asked about their primary fuel for cooking. The results show that 91 percent of households use solid fuel for cooking—mostly wood, animal dung, and straw, shrubs, and grass. LPG/natural gas and electricity are used by 10 percent of households.

The potential for exposure to harmful effects of smoke from using solid fuels for cooking increases if cooking occurs within the home itself rather than outdoors or in a separate building. Seventy-seven percent of households cook in the house, 16 percent cook in a separate building, and 7 percent cook outdoors.

Information on frequency of smoking inside the home was obtained to assess the percentage of households in which there is exposure to second-hand smoke, which causes health risks in children and adults who do not smoke. Pregnant women who are exposed to secondhand smoke have a higher risk of delivering a low birth weight baby (Windham et al., 1999), and children exposed to second-hand smoke are at increased risk for respiratory and ear infections and poor lung development (U.S. Department of Health and Human Services, 2006). Only 7 percent of the surveyed households' report that someone smokes at the home daily, 1 percent report that someone smokes at least once a week, and less than one percent report that someone smokes monthly or less. In 92 percent of households, smoking never occurs in the home.

Table 4\_2.3 Household characteristics

Percent distribution of households by housing characteristics, percentage using solid fuel for cooking, and percent distribution by frequency of smoking in the home, Afghanistan 2014

Housing characteristic	Total
<b>Electricity</b>	
Yes	79.0
No	21.0
Total	100.0
<b>Place for cooking</b>	
In the house	77.3
In a separate building	16.0
Outdoors	6.7
Total	100.0
<b>Cooking fuel</b>	
Electricity	0.5
LPG/natural gas/biogas	9.0
Coal/lignite	0.5
Charcoal	0.7
Wood	37.5
Straw/shrubs/grass	18.3
Agricultural crop	0.2
Animal dung	33.4
Total	100.0
Percentage using solid fuel for cooking <sup>1</sup>	90.5
<b>Frequency of smoking in home</b>	
Daily	6.6
Weekly	1.4
Monthly	0.2
Less than monthly	0.2
Never	91.5
Total	100.0
Number	1,002

LPG = Liquid petroleum gas

<sup>1</sup> Includes coal/lignite, charcoal, wood, straw/shrubs/grass, agricultural crops, and animal dung

## 2.1.4. Housing Construction Materials

Table 2.4 shows households' construction material for walls, roof and floors. The materials used for construction of these items are directly related to socioeconomic status of households. Socioeconomic status is strongly related to population health and also to educational attainment.

The results show that almost all households have natural floors. Eighty percent of households live in houses with floors of mud and hay and another 9 percent live in houses with floors of earth, sand or dung. Only 8 percent of households live in houses with cement floors, while 3 percent have floors with carpets, tiles, or wood planks.

More than 8 in 10 households live in houses with mud walls, either prepared mud (42 percent of households), mud with stones (27 percent), mud with hay (11 percent), or dirt (2 percent). Uncovered/covered adobe accounts for 13 percent of households and cement or bricks form the walls for 4 percent of households.

With regard to roofs, the material used for construction is most often wood or timber (40 percent of households), followed by wood planks (31 percent) and mats or mud and grass (23 percent).

Three in four households have 1-2 rooms for sleeping and just 25 percent had three or more rooms for sleeping.

Table 5\_2.4. Housing materials

Percent distribution of households by housing construction material, Afghanistan 2014

Housing construction material	Total
<b>Flooring material</b>	
Earth, sand	8.2
Dung	1.2
Mud and hay	79.9
Wood/planks	0.1
Ceramic tiles	0.1
Cement	8.0
Carpet	2.6
Total	100.0
<b>Wall material</b>	
No walls	0.7
Prepared mud	42.4
Dirt	1.7
Hay with mud	11.1
Stone with mud	27.0
Uncovered adobe	6.6
Reused wood	0.1
Cement	0.6
Cement/bricks	3.7
Covered adobe	6.0
Other	0.1
Total	100.0
<b>Roof material</b>	
Thatch/bushes/grass	2.8
Sod/mud with grass	0.9
Rustic mat/mud with hay	23.1
Wood planks	30.9
Cardboard/cloth/tent	0.2
Metal	0.7
Wood/timber	39.7
Ceramic tiles	0.6
Cement/bricks	0.9
Roofing shingles	0.2
Other	0.1
Total	100.0
<b>Rooms used for sleeping</b>	
One	33.4
Two	41.0
Three or more	25.1
Missing	0.5
Total	100.0
Number	1,002

## 2.1.5 Household Possessions

The availability of durable goods is an indicator of a household's socioeconomic status. Moreover, each particular item has specific benefits. For instance, having access to a radio, a television, or the internet can expose household members to innovative ideas. Table 2.5 shows information about the ownership of selected household possessions.

Less than half of households (41 percent) report owning a television, while 80 percent of households have mobile telephones. More than four in five households (43 percent) own a device for playing DVDs. More than one-third of households own a radio and only 4 percent have internet access.

Transportation in mountainous areas can be life-saving, especially in case of the need for transporting patients to a health facility. Survey results reflect that most of the households in the surveyed areas have low socioeconomic status, e.g., only four percent own a car or truck, only 16 percent have a motorcycle and just 7 percent own bicycles.

## 2.1.6 Frequency of Consumption of Meat and Fruits and Vegetables

In the 2014 AHNS, interviewers asked the household respondent how many days in the previous week the household ate meat. As shown in Table 2.6, 8 percent of households reported eating meat three or more times in the week before the survey. More than four in ten households did not eat meat at all in the previous week. Households were also asked whether they consumed fruits or vegetables in the week before the survey. Only one in four households ate fruits or vegetables three or more times in the week before the interview.

Table 6\_2.5 Household possessions

Percentage of households possessing various household effects, Afghanistan 2014

Possession	Total
<b>Household effects</b>	
Radio	36.6
Television	40.8
Mobile telephone	80.1
Fan	18.7
Mattress	88.7
Cabinet	43.2
Generator	4.2
DVD player	43.2
Internet	4.2
<b>Means of transport</b>	
Bicycle	7.3
Animal drawn cart	0.1
Motorcycle/scooter	15.7
Car/truck	3.9
Rickshaw	0.7
Number	1,002

Table 7\_2.6 Frequency of household consumption of meat, fruits and vegetables

Percent distribution of households by number of days in the past week in which they consumed meat and consumed fruits or vegetables, Afghanistan 2014

	Number of days in past week household consumed meat					Number of days in past week household consumed fruits or vegetables					Number of households
	0	1	2	3+	Total	0	1	2	3+	Total	
Total	42.1	32.2	17.5	8.1	100.0	46.7	14.0	15.1	24.2	100.0	1,002

## 2.1.7 Salt Storage

Salt iodization in Afghanistan is one of the essential components of the nutrition program. Edible salt should be iodized at the point of production; however, the iodine content can be depleted if salt is stored poorly. As part of the AHNS, interviewers asked if they could see where the household stored its salt. For 88 percent of the households, the place where the salt was stored was observed by the interviewer. In 70 percent of households, the salt was stored in a closed container, whereas in 30 percent of households the salt was stored in open containers (table not shown).

## 2.2 Hand Washing

Hand washing with soap and water is ideal. However, hand washing with a non-soap cleansing agent such as ash or sand is an improvement over not using any cleansing agent. To obtain hand-washing information, interviewers asked to see the place where members of the household most often washed their hands; information on the availability of water, cleansing agents, or both was recorded only for households where the hand washing place was observed. Interviewers observed the place most often used for hand washing in 79 percent of households. Among those households where the hand washing place was observed, 42 percent had soap and water, 11 percent had water and a cleansing agent other than soap, 17 percent had only water, 5 percent had soap or another cleansing agent but no water, and 25 percent had no water, soap, or any other cleansing agent at the hand washing place.

**Table 8\_2.7 Hand washing**

Percentage of households in which the place most often used for washing hands was observed, and among households in which the place for hand washing was observed, percent distribution by availability of water, soap and other cleansing agents, Afghanistan 2014

Percentage of households where place for washing hands was observed	Number of households	Among households where place for hand washing was observed, percentage with:							Total	Number of households with place for hand washing observed
		Soap and water <sup>1</sup>	Water and cleansing agent <sup>2</sup> other than soap only	Water only	Soap but no water <sup>3</sup>	Cleansing agent other than soap only <sup>2</sup>	No water, no soap, no other cleansing agent			
Total	79.1	1,002	42.1	10.7	17.3	2.6	2.1	25.3	100.0	793

<sup>1</sup> Soap includes soap or detergent in bar, liquid, powder or paste form. This column includes households with soap and water only as well as those that had soap and water and another cleansing agent.

<sup>2</sup> Cleansing agents other than soap include locally available materials such as ash, mud or sand

<sup>3</sup> Includes households with soap only as well as those with soap and another cleansing agent

## 2.3 Household Population by Age and Sex

Age and sex are important demographic variables that are the primary basis for demographic classification in vital statistics, censuses, and surveys. They are also very important variables in the study of mortality, fertility, and marriage. The distribution of the de facto household population in the 2014 AHNS is shown in Table 2.8 by five-year age groups, according to sex. A total of 6,540 individuals resided in the 1,002 households successfully interviewed; the population was nearly evenly distributed between males (3,230) and females (3,310).

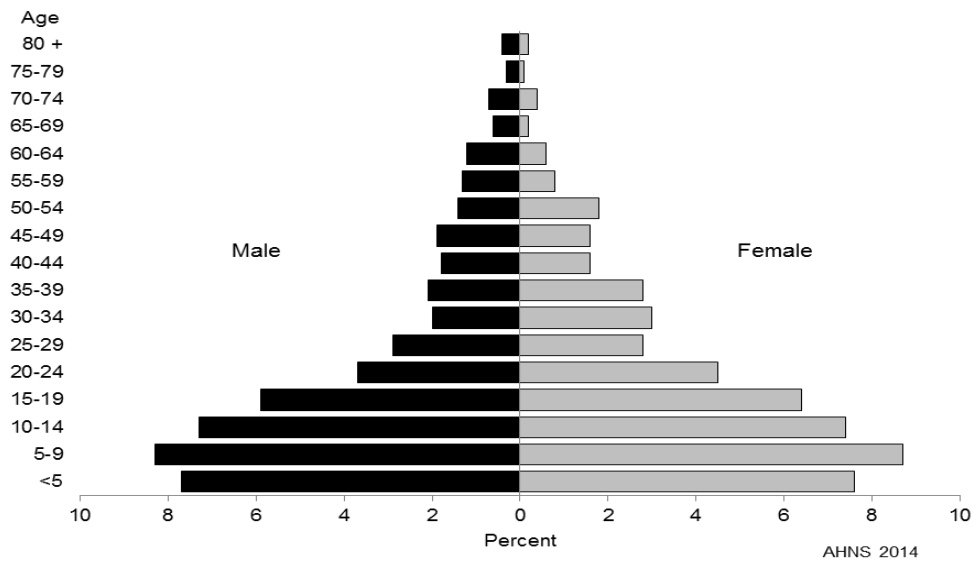
The age-sex structure of the population is shown in the population pyramid in Figure 2.1. The broad base of the pyramid indicates that the population is young, a scenario typical of countries with high fertility rates. The reported proportion of persons under age 15 was 47 percent in 2014, while the proportion of individuals age 65 and older was 3 percent.

**Table 9\_2.8 Household population by age and sex**

Percent distribution of the de facto household population by five-year age groups, according to sex, Afghanistan 2014

Age	Male	Female	Total
0-4	15.5	15.0	15.2
5-9	16.8	17.1	17.0
10-14	14.7	14.6	14.7
15-19	11.9	12.7	12.3
20-24	7.4	8.9	8.2
25-29	5.9	5.5	5.7
30-34	4.0	6.0	5.0
35-39	4.3	5.6	5.0
40-44	3.7	3.2	3.4
45-49	3.8	3.2	3.5
50-54	2.9	3.6	3.3
55-59	2.6	1.6	2.1
60-64	2.4	1.2	1.8
65-69	1.3	0.5	0.9
70-74	1.5	0.8	1.1
75-79	0.5	0.1	0.3
80 +	0.8	0.5	0.6
Total	100.0	100.0	100.0
Number	3,230	3,310	6,540

Figure 1\_2.1: Population pyramid



## 2.4 Household Composition

Information on the composition of households, including the sex of the head of the household and the size of the household, is presented in Table 2.9. These characteristics are important because they are associated with the welfare of the household. Female-headed households are, for example, typically poorer than male-headed households. In larger households, economic resources are often more limited. Moreover, where the household size is large, crowding can lead to health problems.

Table 2.9 shows that 79 percent of the households in the survey areas are headed by men. Households in the surveyed area are quite large. While households with one or two members constitute only 5 percent of all households, those with nine or more members account for the largest proportion (26 percent) of all households. The overall average household size was 6.8 percent.

Information was also collected on the living arrangements of all children under age 18 residing in households and on the survival status of their parents. These data can be used to assess the extent to which households face a need to care for orphaned or foster children. Orphans include children whose mother or father has died (single orphans) as well as children who have lost both parents (double orphans). In the case of foster children, both parents are alive but the children are living in a household where neither their natural mother nor their natural father resides. Overall, 12 percent of households in the survey areas are caring for foster or orphaned children, or both.

**Table 10\_2.9 Household composition**

Percent distribution of households by sex of head of household and by household size; mean size of household, and percentage of households with orphans and foster children under 18 years of age, Afghanistan 2014

<u>Characteristic</u>	<u>Total</u>
<b>Household headship</b>	
Male	79.1
Female	20.9
Total	100.0
<b>Number of usual members</b>	
1	0.6
2	4.0
3	8.5
4	10.4
5	11.5
6	12.8
7	13.1
8	12.8
9+	26.3
Total	100.0
Mean size of households	6.8
<b>Households with orphans/ foster children under 18 years of age</b>	
Foster children <sup>1</sup>	6.2
Double orphans	2.1
Single orphans <sup>2</sup>	7.5
Foster and/or orphan children	12.2
Number of households	1,002

Note: Table is based on de jure household members, i.e., usual residents.

<sup>1</sup> Foster children are those under age 18 living in households with neither their mother nor their father present.

<sup>2</sup> Includes children with 1 dead parent and unknown survival status of the other parent.

## 2.5 Children's Living Arrangements and Parental Survival

Information was collected on the living arrangements and survival status of parents of all children under age 18 residing in the AHNS sample households to assess the potential burden on households of the need to provide for orphaned or foster children. These data were also used to assess the situation from the perspective of the children themselves. Table 2.10 presents the proportion of children under age 18 who are not living with one or both parents, either because the parent(s) died or for other reasons.

More than 9 in 10 children under 18 are living with both parents (92 percent). Two percent of children are not living with either parent. Five percent of children under age 18 are orphaned, that is, one or both parents are dead. Fostering is not very common in the program areas; less than 1 percent of children under 18 are not living with either of their biological parents, despite the fact that both parents are alive.

The percentage of orphaned children increases rapidly with age, from 1 percent of children under 5 to 11 percent of children age 15-17. Both male and female children are equally likely to be orphaned.

**Table 11\_2.10 Children's living arrangements and orphan hood**

Percent distribution of de jure children under age 18 by living arrangements and survival status of parents, the percentage of children not living with a biological parent, and the percentage of children with one or both parents dead, according to background characteristics, Afghanistan 2014

Background characteristic	Living with both parents	Living with mother but not with father		Living with father but not with mother		Not living with either parent			Total	Percentage not living with a biological parent	Percentage with one or both parents dead <sup>1</sup>	Number of children	
		Father alive	Father dead	Mother alive	Mother dead	Both alive	Only father alive	Only mother alive					Both dead
<b>Age</b>													
0-4	95.2	2.1	1.1	0.0	0.2	1.4	0.1	0.0	0.1	100.0	1.5	1.4	1,039
<2	96.1	2.6	0.8	0.0	0.0	0.4	0.1	0.0	0.0	100.0	0.5	0.9	391
2-4	94.6	1.7	1.3	0.0	0.3	2.0	0.1	0.0	0.1	100.0	2.1	1.7	648
5-9	93.0	2.7	2.0	0.2	0.4	0.2	0.3	0.2	1.0	100.0	1.7	4.0	1,155
10-14	91.2	2.5	2.9	0.2	1.6	0.7	0.3	0.5	0.1	100.0	1.6	5.4	994
15-17	85.3	2.0	4.6	0.6	2.6	1.5	0.0	1.0	2.4	100.0	4.9	10.6	513
<b>Sex</b>													
Male	92.1	2.0	2.8	0.2	0.8	1.2	0.2	0.5	0.2	100.0	2.1	4.5	1,819
Female	91.9	2.7	1.9	0.2	1.1	0.5	0.2	0.2	1.2	100.0	2.1	4.6	1,883
Total <15	93.1	2.4	2.0	0.1	0.7	0.7	0.2	0.2	0.4	100.0	1.6	3.6	3,189
Total <18	92.0	2.4	2.3	0.2	1.0	0.8	0.2	0.4	0.7	100.0	2.1	4.5	3,702

Note: Table is based on de jure members, i.e., usual residents.

<sup>1</sup> Includes children with father dead, mother dead, both dead and one parent dead but missing information on survival status of the other parent.

## 2.6 Education of the Household Population

The educational level of household members is among the most important characteristics of the household because it is associated with many factors that have a significant impact on health-seeking behavior, reproductive behavior, use of contraception, and the health of children.

The formal education system in Afghanistan has several levels: primary (grades 1-6); basic intermediate (grades 7-9); secondary/high school (grades 10-12); professional primary/middle (specialized technical or vocational school programs involving two or three grades each); and higher (university or postgraduate programs). Individuals who attended or completed the intermediate level (grades 5-9) and those who attended but did not complete the secondary level (grades 10-12) are combined in the “some secondary” category. The “completed secondary” category includes individuals who completed grade 12.

### 2.6.1 Educational Attainment

Tables 2.11.1 and 2.11.2 show the distribution of female and male household members age 6 and above by the highest level of schooling ever attended and/or completed and the median number of years of education completed according to age. Very few women are educated. Over 60 percent of women age 6 and older have never attended school and an additional 20 percent attended but did not complete primary school. Only 2 percent of women have a post-secondary education and only 3 percent completed secondary school or higher. The median number of years of school completed is 0 for women.

The educational attainment of men is slightly better than that of women. They are more likely to have attended school and are slightly more likely than women to have at least attended some secondary school or higher (21 percent for men and 14 percent for women). Nevertheless, since just over half of men aged 6 and over have never attended school, the median years of school completed for men is also 0.



**Table 12\_2.11.1 Educational attainment of the female household population**

Percent distribution of the de facto female household population age six and over by highest level of schooling attended or completed and median years completed, according to background characteristics, Afghanistan 2014

Age	No education	Incomplete primary	Completed primary	Incomplete secondary	Completed secondary	Higher	Total	Number	Median years completed
6-9	50.5	48.0	1.0	0.5	0.0	0.0	100.0	456	0.0
10-14	25.2	45.0	14.2	15.4	0.3	0.0	100.0	484	3.3
15-19	39.5	12.3	2.0	35.0	8.6	2.7	100.0	420	4.8
20-24	59.6	9.3	0.5	21.1	0.8	8.6	100.0	295	0.0
25-29	88.5	1.2	2.4	1.4	2.0	4.4	100.0	182	0.0
30-34	93.5	3.9	0.6	1.5	0.5	0.0	100.0	197	0.0
35-39	94.1	1.5	1.7	2.3	0.2	0.1	100.0	184	0.0
40-44	97.8	1.6	0.3	0.3	0.0	0.0	100.0	104	0.0
45-49	95.2	1.4	0.0	3.4	0.0	0.0	100.0	105	0.0
50-54	96.2	2.7	0.7	0.3	0.0	0.0	100.0	120	0.0
55-59	98.9	1.1	0.0	0.0	0.0	0.0	100.0	53	0.0
60-64	(100.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	100.0	40	(0.0)
65+	99.1	0.9	0.0	0.0	0.0	0.0	100.0	61	0.0
Total	62.3	19.8	3.4	11.1	1.6	1.7	100.0	2,703	0.0

Note: Total includes 1 woman with age not stated. Figures in parentheses are based on 25-49 unweighted cases.

<sup>1</sup> Completed grade 6 at the primary level

<sup>2</sup> Completed 6 years at the secondary level (i.e., grade 12)

**Table 13\_2.11.2 Educational attainment of the male household population**

Percent distribution of the de facto male household population age six and over by highest level of schooling attended or completed and median years completed, according to background characteristics, Afghanistan 2014

Age	No education	Incomplete primary	Completed primary	Incomplete secondary	Completed secondary	Higher	Total	Number	Median years completed
6-9	52.8	46.7	0.3	0.0	0.3	0.0	100.0	477	0.0
10-14	18.7	48.9	16.2	16.0	0.2	0.0	100.0	475	3.7
15-19	27.4	15.1	3.6	40.9	9.5	3.5	100.0	384	6.4
20-24	42.7	8.9	3.2	26.5	6.5	12.1	100.0	239	4.3
25-29	57.2	12.6	1.0	22.8	1.1	5.3	100.0	190	0.0
30-34	73.0	11.1	3.7	7.3	1.9	3.0	100.0	129	0.0
35-39	70.2	11.1	4.6	9.8	1.0	3.3	100.0	141	0.0
40-44	81.0	11.1	1.8	2.0	0.1	4.1	100.0	119	0.0
45-49	68.8	13.4	0.6	15.0	0.0	2.1	100.0	121	0.0
50-54	79.4	2.9	2.4	10.3	0.0	5.0	100.0	94	0.0
55-59	70.7	13.1	0.1	11.6	0.0	4.6	100.0	83	0.0
60-64	85.3	8.4	0.7	4.9	0.0	0.7	100.0	78	0.0
65+	93.0	2.5	0.0	4.0	0.0	0.6	100.0	131	0.0
Total	50.8	24.1	4.5	15.5	2.3	2.9	100.0	2,663	0.0

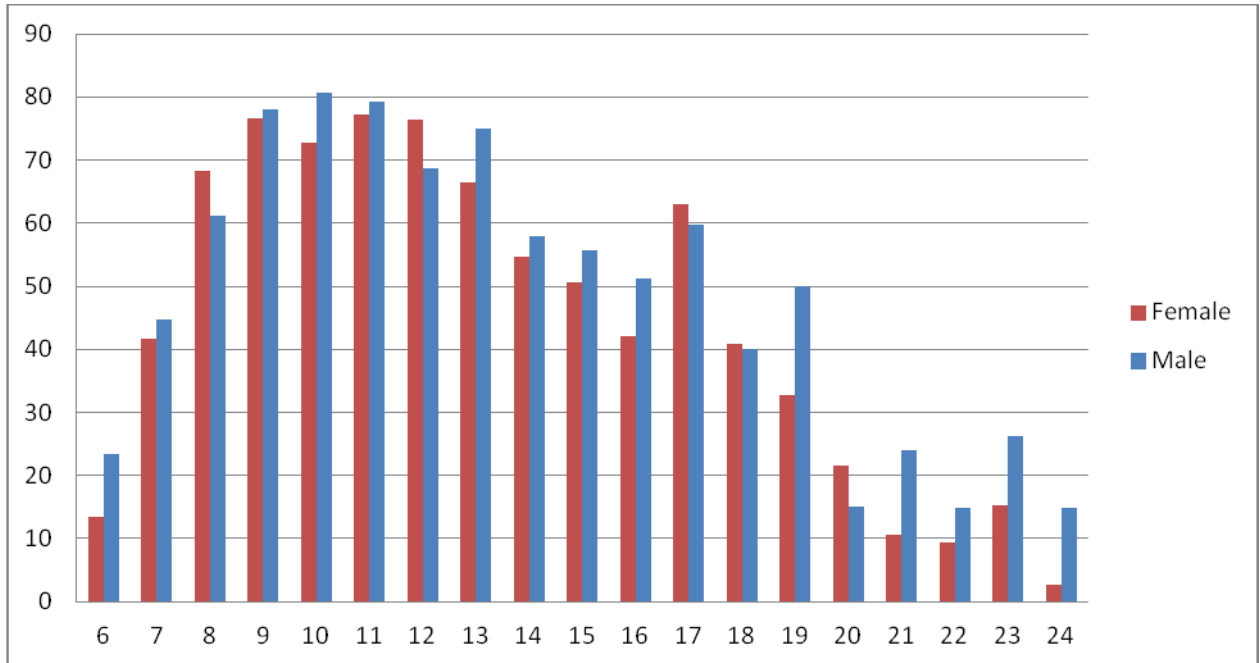
<sup>1</sup> Completed grade 6 at the primary level

<sup>2</sup> Completed 6 years at the secondary level (i.e., grade 12)

## 2.6.2 School Attendance Ratios

Figure 2.2 presents information on age-specific school attendance rates for the population age 6-24. Attendance levels are low among children age 6, since children are not expected to enter school until age 7. At most ages, the proportion attending school is higher for males than females. Among children age 9-11, attendance rates are close to 80 percent. Among the population age 18-24, attendance rates decline rapidly, and the gender gap increases with age. For example, among those age 18, only 40 percent of both males and female are attending school. Among those age 21, only 24 percent of males and 11 percent of females are still in school.

Figure 2\_2.2: Age-specific attendance rates of the de-facto population 6 to 24 years



## Key Findings

- A total of 979 ever-married women age 15-49 were interviewed in the 2014 AHNS.
- Education levels are low; only 13 percent of ever-married women have attended school, with 7 percent attending secondary school only and just one percent continuing beyond the secondary level.
- 4 percent of ever-married women read newspapers at least once a week, while 40 percent watch television and 26 percent listen to the radio at least once a week.
- Women marry very early in the program areas; half have married by age 17 years.

This chapter presents information on demographic and socioeconomic characteristics of the survey respondents such as age, education, exposure to mass media, and marital status. This information is useful for understanding the factors that affect use of reproductive health services, contraceptive use, and other health behaviors.

### 3.1 General Characteristics of Survey Respondents

Background characteristics of the 979 ever-married women age 15-49 interviewed in the 2014 AHNS are presented in Table 3.1. The proportion of respondents in each age group generally declines with increasing age.

Ninety-seven percent of ever-married women were currently married, while 3 percent were widowed. The percentage who were divorced or separated was very low.

Generally, educational attainment is very low; only 13 percent of ever-married women age 15-49 reported that they had ever attended school, while 87 percent had no education. Five percent of ever-married women attended primary school only, while 7 percent of women reached secondary school (grades 7-12) and stopped, and 1 percent attained a higher level (professional primary/middle, university, or post-graduate).

**Table 14\_3.1 Background characteristics of respondents**

Percent distribution of ever-married women age 15-49 by selected background characteristics, Afghanistan 2014

Background characteristic	Weighted percent	Number of women	
		Weighted number	Unweighted number
<b>Age</b>			
15-19	3.9	38	50
20-24	20.6	200	184
25-29	15.8	153	186
30-34	19.4	189	171
35-39	19.1	186	181
40-44	10.3	101	113
45-49	11.0	107	94
<b>Marital status</b>			
Married	96.8	943	953
Divorced/separated	0.1	1	1
Widowed	3.1	30	25
<b>Education</b>			
No education	86.8	845	795
Primary	5.2	50	86
Secondary	7.0	68	82
Higher	1.1	10	16
Total 15-49	100.0	974	979

Note: Education categories refer to the highest level of education attended, whether or not that level was completed.

### 3.2 Educational Attainment by Age

Table 3.2 presents an overview of female respondents' educational attainment, according to age group. Overall, the results show a low level of education attainment in Afghanistan among female

respondents. Only 9 percent of ever-married women age 15-49 have completed primary school or more and only 1 in 100 have completed secondary school. Since the vast majority of women have never been to school, the median years of schooling completed is 0. There is evidence of improvement among younger women, however; women age 15-19 have completed a median of 4.9 years of schooling.

**Table 15\_3.2 Educational attainment**

Percent distribution of ever-married women age 15-49 by highest level of schooling attended or completed, and median years completed, according to background characteristics, Afghanistan 2014

Age	Highest level of schooling						Total	Median years completed	Number of women
	No education	Incomplete primary	Complete primary	Incomplete secondary	Complete secondary	Higher			
15-24	63.3	11.5	1.4	20.5	0.0	3.3	100.0	0.0	238
15-19	44.6	9.7	3.1	38.1	0.0	4.5	100.0	4.9	38
20-24	66.9	11.8	1.1	17.1	0.0	3.1	100.0	0.0	200
25-29	93.7	1.2	0.4	3.3	0.0	1.4	100.0	0.0	153
30-34	93.8	3.0	0.6	2.7	0.0	0.0	100.0	0.0	189
35-39	94.5	2.0	0.4	1.9	1.2	0.0	100.0	0.0	186
40-44	96.5	3.1	0.4	0.0	0.0	0.0	100.0	0.0	101
45-49	94.4	2.2	0.0	3.1	0.0	0.2	100.0	0.0	107
Total	86.8	4.5	0.6	6.8	0.2	1.1	100.0	0.0	974

<sup>1</sup> Completed grade 6 at the primary level

<sup>2</sup> Completed 6 years at the secondary level (i.e., grade 12)

### 3.3 Literacy

The ability to read and write is an important personal asset, allowing individuals increased opportunities in life. Knowing the distribution of the literate population can help program managers, especially for health and family planning; know how to reach women with their messages. In the 2014 AHNS, the literacy status of ever-married women who had not attended school or had attended only primary school was determined by their ability to read all or part of a sentence. Those with secondary education or higher were assumed to be literate.

**Table 16\_3.3 Literacy**

Percent distribution of ever-married women age 15-49 by level of schooling attended and level of literacy, and percentage literate, according to age, Afghanistan 2014

Age	Secondary school or higher	No schooling or primary school			Total	Percentage literate <sup>1</sup>	Number of women
		Can read a whole sentence	Can read part of a sentence	Cannot read at all			
15-24	23.8	5.7	7.9	62.7	100.0	37.3	238
15-19	42.6	3.7	4.6	49.1	100.0	50.9	38
20-24	20.2	6.0	8.5	65.3	100.0	34.7	200
25-29	4.7	0.5	1.4	93.4	100.0	6.6	153
30-34	2.7	0.0	3.4	93.9	100.0	6.1	189
35-39	3.1	0.1	2.6	94.2	100.0	5.8	186
40-44	0.0	0.8	0.8	98.4	100.0	1.6	101
45-49	3.4	0.0	1.7	94.9	100.0	5.1	107
Total	8.0	1.6	3.6	86.8	100.0	13.2	974

<sup>1</sup> Refers to women who attended secondary school or higher and women who can read a whole sentence or part of a sentence

Table 3.3 shows the percent distribution of ever-married women by level of schooling attended and level of literacy, along with the percentage of respondents who are literate, according to background characteristics. Literacy is not common among women age 15-49 years in the program areas; only 13

percent have either attended secondary school or could read most or all of the sentence provided by the interviewer. Literacy declines with age.

### 3.4 Exposure to Mass Media

The 2014 AHNS collected information on respondents' exposure to common print and electronic media. Respondents were asked how often they read a newspaper, watched television or listened to the radio. This information indicates the extent to which women are regularly exposed to mass media, often used to convey messages on health topics. Table 3.4 shows the percentage of ever-married women age 15-49 who were exposed to different types of mass media by background characteristics.

**Table 17\_3.4 Exposure to mass media**

Percentage of ever-married women age 15-49 who are exposed to specific media on a weekly basis, by background characteristics, Afghanistan 2014

Background characteristic	Reads a newspaper at least once a week	Watches television at least once a week	Listens to the radio at least once a week	Accesses all three media at least once a week	Accesses none of the three media at least once a week	Number of women
<b>Age</b>						
15-19	7.7	45.9	27.2	1.1	37.3	38
20-24	13.6	49.1	34.9	9.5	32.7	200
25-29	3.3	30.7	13.7	1.2	63.4	153
30-34	2.1	38.5	25.4	0.5	49.9	189
35-39	1.3	39.9	23.5	0.0	52.7	186
40-44	0.0	36.4	23.7	0.0	52.6	101
45-49	0.7	35.6	30.2	0.0	52.9	107
<b>Education</b>						
No education	0.8	35.4	23.4	0.0	53.5	845
Primary	4.1	68.3	30.5	0.0	23.8	50
Secondary	45.2	67.2	47.1	29.6	16.6	68
Higher	*	*	*	*	*	10
Total	4.4	39.5	25.6	2.3	49.1	974

Only 4 percent of ever-married women read newspapers at least once a week, while 40 percent watch television at least once a week, and 26 percent listen to the radio at least once a week. Newspaper reading is more or less confined to younger women and those with some education, especially those who have attended secondary school. The proportion of women who watch television and who listen to the radio increases with educational attainment.

### 3.5 Marital Status

Marriage is a primary indication of the exposure of women to the risk of pregnancy and therefore is important to the understanding of fertility. Populations in which women marry at a young age tend to initiate childbearing early and have high fertility. More direct measures of the beginning of exposure to pregnancy are age at first intercourse and frequency of intercourse.

Table 3.5 shows the percent distribution of all women age 15-49 by current marital status. Because only women who had ever married were interviewed in the AHNS, the number of women in the denominator of the percentages was inflated by factors calculated from information in the Household Questionnaire on the proportions ever married to produce a count of all women.

Results show that two-thirds of all women age 15-49 have ever been married, while one-third are never-married. The proportion of women who have never married declines sharply with age, from 91 percent of women age 15-19 to 0 percent of those age 45-49. Marriage is thus eventually a universal

event. As expected, the proportion of women who are widowed increases with age; among women age 45-49, 12 percent are widowed.

**Table 18\_3.5 Current marital status**

Percent distribution of all women age 15-49 by current marital status, according to age, Afghanistan 2014

Age	Marital status				Total	Percentage of respondents currently in union	Number of respondents
	Never married	Married	Divorced	Widowed			
15-19	90.7	9.3	0.0	0.0	100.0	9.3	408
20-24	32.6	66.6	0.0	0.8	100.0	66.6	297
25-29	12.2	87.8	0.0	0.0	100.0	87.8	175
30-34	2.0	96.2	0.4	1.4	100.0	96.2	192
35-39	0.0	99.2	0.0	0.8	100.0	99.2	186
40-44	3.9	85.1	0.0	11.1	100.0	85.1	105
45-49	0.0	88.5	0.0	11.5	100.0	88.5	107
Total 15-49	33.8	64.1	0.1	2.1	100.0	64.1	1,471

### 3.6 Age at First Marriage

For most societies, marriage marks the point in a woman's life when childbearing first becomes socially acceptable. Women who marry early will, on average, have longer exposure to pregnancy and a greater number of lifetime births. Information on age at first marriage was obtained by asking all ever-married women the month and year they got married or started living together with their first husband.

Table 3.6 presents the percentage of all women age 15-49 who first married by specific exact ages and their median age at first marriage. Overall, almost three in five women age 25-49 married by the time they were 18, and three in four married by age 20. One in four women was married before the age of 15. The median age at marriage is 17 years. The median age at marriage among women fluctuates across age groups, showing no steady pattern.

**Table 19\_3.6 Age at first marriage**

Percentage of all women age 15-49 who were first married by specific exact ages and median age at first marriage, according to current age, Afghanistan 2014

Current age	Percentage first married by exact age:					Percent-age never married	Number of respondents	Median age at first marriage
	15	18	20	22	25			
15-19	2.6	na	na	Na	na	90.7	408	a
20-24	13.8	39.4	60.7	Na	na	32.6	297	19.0
25-29	16.0	46.1	68.2	76.7	82.6	12.2	175	18.3
30-34	30.6	64.0	75.5	88.6	94.3	2.0	192	15.9
35-39	22.5	65.3	78.9	89.5	97.1	0.0	186	16.4
40-44	25.8	55.1	69.4	86.9	93.1	3.9	105	17.2
45-49	23.1	52.7	73.5	89.1	95.7	0.0	107	17.7
20-49	20.9	52.4	70.0	Na	na	11.9	1,062	17.7
25-49	23.6	57.4	73.5	85.9	92.4	3.8	765	17.0

Note: The age at first marriage is defined as the age at which the woman began living with her first husband

na = Not applicable due to censoring

a = Omitted because less than 50 percent of the women began living with their husband for the first time before reaching the beginning of the age group

**Key Findings**

- The total fertility rate for the program areas is 5.2 children per woman.
- 10 percent of all women age 15-49 were pregnant at the time of the survey.
- The median interval between births is 32 months.
- Childbearing in the program areas starts relatively late; the median age at first birth among women age 25-49 is 20 years.

**I**n the AHNS, data were collected on current and completed fertility. The birth histories of women interviewed in the survey were used to calculate age-specific and total fertility rates. The chapter also shows data on the age of women at their first birth and on patterns of teenage childbearing.

The fertility indicators presented in this chapter are based on reports of reproductive histories provided by ever-married women age 15-49. Each woman was first asked to provide information on the total number of sons and daughters to whom she had given birth and who were living with her, the number living elsewhere, and the number who had died, in order to obtain the total number of live births. In the birth history, women reported the details of each live birth separately, including such information as name, sex, month and year of birth, and survival status. For children who had died, age at death was recorded.

#### 4.1 Current Fertility

Measures of current fertility include age-specific fertility rates (ASFRs), the total fertility rate (TFR), the general fertility rate (GFR), and the crude birth rate (CBR). These rates are presented for the three-year (36-month) period preceding the survey, a period that covers a portion of calendar year 2011, all of 2012 and 2013 and most of 2014. The three-year period (rather than a longer or a shorter period) was chosen to calculate rates as a compromise among three criteria: to get the most current information, to reduce sampling error, and to avoid problems noted in previous surveys of the displacement of births from 5 to 6 years before the survey.

Age-specific fertility rates are useful in understanding the age pattern of fertility. Numerators of ASFRs are calculated by summing the number of live births that occurred in the period 1-36 months preceding the survey (determined from the date of interview and date of birth of the child) and classifying them by the age of the mother (in five-year groups) at the time of the child's birth (determined by the mother's date of birth). The denominators of these rates are the number of woman-years lived by the survey respondents in each of the five-year age groups during the specified period. Because only women who had ever married were interviewed in the AHNS, the number of women in the denominator of the rates was inflated by factors calculated from information in the Household Questionnaire on the proportions ever married to produce a count of all women. Never-married women are presumed not to have given birth.

The TFR is a common measure of current fertility and is defined as the number of children a woman would have by the end of her childbearing years if she were to pass through those years bearing children at the current age-specific fertility rates. The GFR represents the number of live births per 1,000 women of reproductive age. The CBR is the number of live births per 1,000 population. The latter two measures are based on birth history data for the three-year period before the survey and on the age-sex distribution of the household population. The TFR is obtained by summing the ASFRs and multiplying by five.

Table 4.1 shows the age-specific and aggregate fertility measures calculated from the 2014 AHNS. The total fertility rate for the program areas is 5.2 children per woman. Childbearing peaks during age 20-24 and drops sharply after age 39. The general fertility rate (GFR) is 169 per 1,000 women age 15-44, while the crude birth rate is 36 births per 1,000 population.

The fertility level of 5.2 is almost the same as the TFR of 5.1 reported for the whole country by the 2010 Afghanistan Mortality Survey (AMS). Fertility in the program areas would be expected to be higher than at the national level since the areas are more rural and less developed than the country as a whole. The GFR of 169 as measured in the AHNS is also the same with the rate of 165 measured in the AMS for the whole country. However, the crude birth rate of 36 is identical to that for the entire country as measured in the 2010 AMS. Comparisons with the AMS are not straightforward since the program areas surveyed in the AHNS are mostly mountainous regions.

## 4.2 Fertility Differentials

One of the strongest relationships with fertility levels occurs by education of women. In addition to education's effect on knowledge of contraceptive methods and reduced fertility preferences, Table 4.2 shows differentials in fertility by level of education. The TFRs for women with only secondary education and women who have attended more than secondary school are 3.5 and 1.0 children per woman, respectively. The fertility rate gradually increases with lower education levels and is highest for women who did not attend school.

Table 4.2 also allows for a general assessment of differential trends in fertility over time among population subgroups. The mean number of children ever born to women age 40-49 is a measure of past fertility. The mean number of children ever born to older women who are nearing the end of their reproductive period is an indicator of average completed fertility of women who began childbearing during the three decades preceding the survey. If fertility were to remain constant over time, and the reported data on children ever born and births during the three years preceding the survey were reasonably accurate, the TFR and the mean number of children ever born for women age 40-49 would be similar. If fertility levels have fallen, the TFR will be substantially lower than the mean number of children ever born among women age 40-49. Comparison of past (completed) fertility and current fertility (TFR) suggests that fertility has decreased from 6.4 to 5.2 children per woman.

At the time of the survey, 10 percent of all women reported that they were pregnant. This percentage is an underestimate because many women will not yet know for sure that they are pregnant, and other women may not want to declare that they are pregnant.

**Table 20\_4.1 Current fertility**

Age-specific and total fertility rates, the general fertility rate, and the crude birth rate for the three years preceding the survey, Afghanistan 2014

Age group	Total
15-19	81
20-24	254
25-29	238
30-34	217
35-39	157
40-44	(68)
45-49	(20)
TFR(15-49)	5.2
GFR	169
CBR	35.7

Notes: Age-specific fertility rates are per 1,000 women. Rates for age 45-49 may be slightly biased due to truncation. Rates are for the period 1-36 months prior to interview. Figures in parentheses are based on 125-249 unweighted woman-years of exposure.

TFR: Total fertility rate expressed per woman

GFR: General fertility rate expressed per 1,000 women age 15-44

CBR: Crude birth rate, expressed per 1,000 population

**Table 21\_4.2 Fertility by background characteristics**

Total fertility rate for the three years preceding the survey, percentage of all women age 15-49 currently pregnant, and mean number of children ever born to all women age 40-49 years, by education, Afghanistan 2014

Education	Total fertility rate	Percentage of all women age 15-49 currently pregnant	Mean number of children ever born to all women age 40-49
No education	5.6	12.1	6.3
Primary	4.4	11.8	*
Secondary	3.5	2.3	*
Higher	1.0	2.4	*
Total	5.2	10.1	6.4

Note: Total fertility rates are for the period 1-36 months prior to interview. An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.



### 4.3 Fertility Trends

The data in Table 4.3 provide some evidence of fluctuations in fertility in the project areas in Afghanistan over the past 20 years. The table uses information from the retrospective birth histories obtained from AHNS respondents to examine trends in age-specific fertility rates for successive five-year periods before the survey. To calculate these rates, births were classified according to the period of time in which the birth occurred and the mother's age at the time of birth. The number of woman-years of exposure was inflated to represent all women and not just ever-married women. Because women age 50 and above were not interviewed in the survey, the rates are successively truncated for periods more distant from the survey date. For example, rates cannot be calculated for women age 35-39 for the period 15 to 19 years before the survey because these women would have been over the age of 50 at the time of the 2014 AHNS and not interviewed. Moreover, the rates should be viewed with caution, given the relatively small sample of women interviewed in the AHNS.

**Table 22\_4.3 Trends in age-specific fertility rates**

Age-specific fertility rates for five-year periods preceding the survey, by mother's age at the time of the birth, Afghanistan 2014

Mother's age - at birth	Number of years preceding survey			
	0-4	5-9	10-14	15-19
15-19	83	168	190	193
20-24	253	310	344	309
25-29	255	381	294	337
30-34	219	263	340	[243]
35-39	147	212	[202]	
40-44	74	[133]		
45-49	[18]			

Note: Age-specific fertility rates are per 1,000 women. Estimates in brackets are truncated. Rates exclude the month of interview.

Results indicate that fertility rates generally fell between the periods 10-14 and 0-4 years before the survey, with the larger decline between 5-9 and 0-4 years before the survey. In sum, the data indicate that there may have been some decrease in fertility levels in the program areas in the recent past.

### 4.4 Children Ever Born and Living

The distribution of women by the number of children ever born is presented in Table 4.4 for all women and for currently married women. The table also shows the mean number of children ever born to women in each five-year age group. These distributions reflect the accumulation of births among AHNS respondents over the past 30 years and, therefore, their relevance to the current situation is limited. However, the information on children ever born is useful for observing how average family size varies across age groups and for observing the level of primary infertility.

On average, women in their early twenties have given birth to one child, women in their early thirties have had around five children, and women at the end of their childbearing years have had almost seven births. Of the 6.7 children ever born to women age 45-49, 5.7 survived to the time of the survey.

Results at younger ages for currently married women differ from those for all women because of the large number of unmarried women with minimal fertility. Differences at older ages generally reflect the impact of marital dissolution (either divorce or widowhood). Three percent of currently married women age 45-49 have never had a child. If the desire for children is universal, this percentage represents a rough measure of primary infertility or the inability to bear children.

**Table 23\_4.4 Children ever born and living**

Percent distribution of all women and currently married women age 15-49 by number of children ever born, mean number of children ever born and mean number of living children, according to age group, Afghanistan 2014

Age	Number of children ever born											Total	Number of women	Mean number of children ever born	Mean number of living children
	0	1	2	3	4	5	6	7	8	9	10+				
<b>ALL WOMEN</b>															
15-19	94.3	3.9	1.6	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	100.0	408	0.08	0.07
20-24	44.9	22.0	14.8	9.3	5.4	3.6	0.0	0.0	0.0	0.0	0.0	100.0	297	1.19	1.13
25-29	20.7	7.7	15.0	23.5	13.3	13.8	5.6	0.4	0.1	0.0	0.0	100.0	175	2.67	2.53
30-34	5.7	4.9	4.7	7.3	19.9	12.9	16.2	17.4	4.1	5.7	1.0	100.0	192	4.94	4.64
35-39	2.1	2.6	6.8	5.7	6.3	18.7	16.8	9.2	15.7	5.8	10.3	100.0	186	5.99	5.33
40-44	6.4	3.7	3.8	0.4	8.6	12.0	12.8	20.0	15.4	10.1	6.6	100.0	105	6.09	5.53
45-49	4.8	0.0	3.0	7.5	7.4	5.4	16.4	22.9	9.4	5.1	18.0	100.0	107	6.70	5.72
Total	39.5	7.7	7.2	6.9	7.3	7.7	7.0	6.6	4.3	2.6	3.2	100.0	1,471	2.91	2.64
<b>CURRENTLY MARRIED WOMEN</b>															
15-19	39.0	42.0	17.1	0.2	1.7	0.0	0.0	0.0	0.0	0.0	0.0	100.0	38	0.84	0.76
20-24	18.4	31.8	22.3	13.9	8.1	5.5	0.0	0.0	0.0	0.0	0.0	100.0	198	1.78	1.68
25-29	9.6	8.8	17.1	26.8	15.2	15.7	6.3	0.4	0.1	0.0	0.0	100.0	153	3.04	2.89
30-34	3.9	5.1	4.4	7.3	20.7	13.5	16.4	17.4	4.3	5.9	1.1	100.0	185	5.05	4.74
35-39	2.1	2.6	6.9	5.7	6.4	18.8	16.1	9.3	15.8	5.8	10.3	100.0	185	5.99	5.33
40-44	3.0	4.4	3.5	0.5	7.1	10.9	14.6	23.6	17.1	9.1	6.2	100.0	89	6.34	5.89
45-49	3.0	0.0	2.5	6.2	7.6	5.7	16.6	25.9	10.3	1.8	20.4	100.0	94	6.92	5.95
Total	8.8	11.7	10.9	10.5	11.0	11.6	10.5	10.1	6.6	3.3	4.9	100.0	943	4.36	3.98

## 4.5 BIRTH INTERVALS

Information on the length of birth intervals provides insight into birth spacing patterns, which affect fertility as well as infant and child mortality. Research has shown that children born too soon after a previous birth are at increased risk of poor health, particularly when the interval is less than 24 months. Table 4.5 shows the distribution of births in the five years before the survey by the interval since the preceding birth, according to various background and demographic characteristics.

The median birth interval in the program areas in Afghanistan is 31.7 months. More than one-quarter of all children are born after too short an interval (less than 24 months). The median birth interval is longer among older women than for younger women.

The median birth interval after the birth of a male child (33 months) is slightly higher than the interval after a female child (31 months), probably indicating a preference for male children. The median birth interval is considerably shorter for children whose previous sibling died than for children whose previous sibling survived (19 and 33 months, respectively). The shorter interval following the death of a child is partly due to a shortened period of breastfeeding (or no breastfeeding) for the preceding child, which leads to an earlier return of ovulation and hence increased chance of pregnancy. Minimal use of contraception, presumably because of a desire to have another child as soon as possible, could also be partly responsible for the shorter birth interval in these cases. Women with some secondary education have a shorter median birth interval (28 months) than women with primary education (32 months).

**Table 24\_4.5 Birth intervals**

Percent distribution of non-first births in the five years preceding the survey by number of months since preceding birth, and median number of months since preceding birth, according to background characteristics, Afghanistan 2014

Background characteristic	Months since preceding birth						Total	Number of non-first births	Median number of months since preceding birth
	7-17	18-23	24-35	36-47	48-59	60+			
<b>Age</b>									
15-19	*	*	*	*	*	*	100.0	6	*
20-29	17.2	18.5	39.1	12.4	7.1	5.7	100.0	347	29.1
30-39	12.4	13.5	33.1	20.4	9.9	10.6	100.0	417	33.6
40-49	6.7	4.2	21.8	33.3	12.9	21.1	100.0	86	41.4
<b>Sex of preceding birth</b>									
Male	13.9	13.1	35.0	16.5	9.5	12.0	100.0	408	33.4
Female	14.1	15.8	34.0	20.1	8.6	7.4	100.0	448	30.5
<b>Survival of preceding birth</b>									
Living	12.7	14.1	34.8	18.9	9.4	10.1	100.0	812	32.8
Dead	38.8	22.9	27.7	7.9	2.5	0.2	100.0	44	18.8
<b>Birth order</b>									
2-3	19.5	15.7	36.9	12.5	9.5	5.9	100.0	282	29.4
4-6	11.7	13.7	36.9	21.2	9.3	7.2	100.0	353	33.4
7+	10.7	14.4	27.5	21.4	7.9	18.1	100.0	221	34.5
<b>Education</b>									
No education	14.1	14.1	33.6	18.5	9.5	10.3	100.0	778	32.0
Primary	10.0	23.7	34.3	16.1	9.1	6.9	100.0	32	31.7
Secondary	9.5	15.0	56.5	17.1	1.8	0.2	100.0	40	27.5
Higher	*	*	*	*	*	*	100.0	6	*
Total	14.0	14.5	34.5	18.4	9.0	9.6	100.0	856	31.7

Note: First-order births are excluded. The interval for multiple births is the number of months since the preceding pregnancy that ended in a live birth. An asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

## 4.6 Age at First Birth

The age at which childbearing begins has an impact on the health and welfare of a mother and her children. In many countries, the postponement of first births has contributed to an overall fertility decline. Table 4.6 shows the distribution of women by age at first birth, according to their current age.

**Table 25\_4.6 Age at first birth**

Percentage of women age 15-49 who gave birth by exact ages, percentage who have never given birth, and median age at first birth, according to current age, Afghanistan 2014

Current age	Percentage who gave birth by exact age					Percentage who have never given birth	Number of women	Median age at first birth
	15	18	20	22	25			
15-19	0.6	na	na	Na	na	94.3	408	a
20-24	8.1	21.4	43.1	Na	na	44.9	297	a
25-29	10.8	31.2	49.4	62.3	76.9	20.7	175	20.1
30-34	22.6	47.9	61.1	70.6	89.4	5.7	192	18.5
35-39	13.3	45.8	57.3	75.9	89.4	2.1	186	18.9
40-44	7.3	35.1	50.6	64.5	78.1	6.4	105	19.9
45-49	6.0	22.8	39.7	55.8	67.9	4.8	107	21.1
20-49	11.8	33.6	50.3	Na	na	18.5	1,062	20.0
25-49	13.2	38.3	53.1	67.1	82.0	8.2	765	19.6

na = Not applicable due to censoring

a = Omitted because less than 50 percent of women had a birth before reaching the beginning of the age group

The median age at first birth in the program areas was 19.6. Analysis by age group shows a decline from a median age at first birth of 21 among women age 45-49 at the time of the survey to a median of 19 among those ages 30-39, and then an increase to 20 among women 25-29.

#### 4.7 Teenage Pregnancy and Motherhood

The issue of adolescent fertility is important for both health and social reasons. Children born to very young mothers are at increased risk of sickness and death. Teenage mothers are more likely to experience adverse pregnancy outcomes and are also more constrained in their ability to pursue educational opportunities than young women who delay childbearing.

Table 4.7 shows the percentage of women age 15-19 who have given birth or were pregnant with their first child at the time of the survey, according to selected background characteristics. Childbearing is quite delayed in survey areas; the results show only a small percentage of girls aged 15-19 (6 percent) have delivered a baby. Overall, 7 percent of women age 15-19 have begun childbearing.

**Table 26\_4.7 Teenage pregnancy and motherhood**

Percentage of all women age 15-19 who have had a live birth or who are pregnant with their first child, and percentage who have begun childbearing, by background characteristics, Afghanistan 2014

Background characteristic	Percentage of women age 15-19 who:		Percentage who have begun childbearing	Number of women
	Have had a live birth	Are pregnant with first child		
<b>Age</b>				
15	0.3	0.0	0.3	116
16	1.5	0.0	1.5	90
17	2.7	1.9	4.5	50
18	11.7	0.7	12.3	112
19	17.1	4.0	21.2	41
<b>Education</b>				
No education	9.1	0.5	9.6	143
Primary	3.9	1.1	5.0	65
Secondary	3.3	0.9	4.2	203
Higher	*	*	*	9
Total	5.7	0.8	6.5	408

Note: The number of women by education differs due to the ever-married expansion factors to calculate all women. An asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

### Key Findings

- More than one-third of married women want no more children and 20 percent are undecided.
- The ideal number of children is 6 for currently married women.
- Overall, 93 percent of births were wanted at the time of conception, 3 percent were mistimed (wanted later), and 4 percent were unwanted.
- The total wanted fertility rate is 4.4 children per woman, compared with the actual total fertility rate of 5.2 children per woman.

Information on fertility preferences is of importance to family planning program planners because it allows an assessment of the need for contraception, whether for spacing or limiting births, and of the extent of unwanted and mistimed pregnancies. Data on fertility preferences can also provide an indication of the direction that future fertility may take. In the 2014 AHNS, ever-married women aged 15-49 were asked whether they wanted more children and, if so, how long they would prefer to wait before the next child. They were also asked, if they could start afresh, how many children they would want.

## 5.1 Fertility Preferences by Number of Living Children

Table 5.1 presents fertility preferences among currently married women by number of living children. When classifying women according to their fertility preferences, the desired timing of the next birth is taken into account. One-third of currently married women in the program areas (33 percent) would like to have a child in the future; however, the vast majority wants to wait two or more years before having their next birth. More than one-third of married women want no more children. Thus, the majority of women (59 percent) want either to delay their next birth (for two or more years into the future) or end childbearing altogether. One in five currently married women is undecided about having another child.

As expected, the desire to have children depends on the number of living children a woman already has. Married women with no children or only 1-2 children are more likely than average to want to have a child soon (within two years). In contrast, the proportion reporting that they do not want another child increases from 11-12 percent among married women with 1-2 children to 60 percent among women with six or more children.

**Table 27\_5.1 Fertility preferences by number of living children**

Percent distribution of currently married women age 15-49 by desire for children, according to number of living children, Afghanistan 2014

Desire for children	Number of living children <sup>1</sup>							Total
	0	1	2	3	4	5	6+	
Have another soon <sup>2</sup>	23.6	21.4	24.8	4.8	4.4	4.5	2.0	9.6
Have another later <sup>3</sup>	5.6	41.2	40.6	38.9	20.9	12.6	10.6	22.6
Have another, undecided when	5.0	0.0	0.4	0.4	0.4	0.3	0.0	0.5
Undecided	33.5	18.9	12.1	20.6	21.4	35.8	13.6	20.4
Want no more	13.8	12.4	11.3	27.9	46.5	37.8	59.8	36.5
Declared in fecund	18.5	6.2	10.7	7.5	6.4	9.1	14.0	10.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	57	122	114	103	116	144	286	943

<sup>1</sup> The number of living children includes the current pregnancy

<sup>2</sup> Wants next birth within 2 years

## 5.2 Ideal Number of Children

Ever-married women were asked what number of children they would choose to have if they could start afresh. Respondents who had no children were asked, “If you could choose exactly the number of children to have in your whole life, how many would that be?” For women who had children, the question was rephrased as follows: “If you could go back to the time when you did not have any children and could choose exactly the number of children to have in your whole life, how many would that be?” Responses to these questions are summarized in Table 5.2 for women age 15-49.

Results show that among ever-married women and currently married women, the mean ideal number of children is 6. Overall, 95 percent of women ideally would want four or more children.

**Table 28\_ 5.2 Ideal number of children by number of living children**

Percent distribution of ever-married women 15-49 by ideal number of children, and mean ideal number of children for ever-married women and for currently married women, according to the number of living children, Afghanistan 2014

Ideal number of children	Number of living children <sup>1</sup>							Total
	0	1	2	3	4	5	6+	
0	5.8	0.0	0.3	0.0	0.0	0.0	0.0	0.4
1	0.0	1.0	1.9	0.0	0.0	0.0	0.5	0.5
2	2.9	6.7	3.7	0.0	0.1	0.6	2.5	2.3
3	2.3	5.5	1.5	9.1	0.2	0.8	0.1	2.2
4	41.1	43.0	33.9	23.3	48.2	15.1	9.2	25.7
5	6.6	8.0	10.5	13.2	8.1	28.2	3.3	10.5
6+	41.2	35.8	48.2	54.4	43.5	55.3	84.5	58.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	60	125	116	106	121	150	296	974
<b>Mean ideal number of children for:<sup>2</sup></b>								
Ever-married women	5.0	4.9	5.2	5.8	5.4	5.9	7.3	6.0
Number of women	60	125	116	106	121	150	296	974
Currently married women	4.8	4.9	5.3	5.8	5.3	5.8	7.3	6.0
Number of currently married women	57	122	114	103	116	144	286	943

Note: Figures in parentheses are based on 25-49 unweighted cases

<sup>1</sup>The number of living children includes current pregnancy for women

When interpreting the findings in Table 5.2, it is important to remember that the actual and stated ideal number of children tend to be related. There are several reasons for this. First, to the extent that women are able to fulfill their fertility desires, women who want large families will achieve large families. Second, because women with large families are, on average, older, they may prefer a greater number of children because of the attitudes towards childbearing to which they were exposed during the early stages of their reproductive lives. Finally, some women may have difficulty admitting that they would prefer fewer children than they currently have if they could begin childbearing again. Such women are likely to report their actual number as their preferred number. Indeed, women who have fewer children do report a smaller ideal number of children than women with more children. Among ever-married women, the mean ideal number of children among childless women is 5.0, compared with 7.3 among those with six or more children.

### 5.3 Mean Ideal Number of Children by Background Characteristics

Table 5.3 shows the mean ideal number of children among ever-married women age 15-49, by background characteristics. The mean ideal number of children generally increases with age, from a low of 5.0 among women age 20-24 to 7.2 among women age 45-49. The mean ideal family size decreases as education level increases.

### 5.4 Couple's Agreement on Family Size

In the AHNS, married women were asked if they thought that their husbands wanted the same number of children that they wanted or more or fewer. Because of an error in the questionnaire, the question was not asked for women who said they ideally would not want any children at all. This omission is not likely to have a large effect on the results, since only four women said their ideal number of children was zero.

Table 5.4 shows that more than half of married women (58 percent) say their husbands want the same number of children they want. The proportion who says their husbands want more (22 percent) is three times higher than the proportion who says their husbands want fewer children than they want (6 percent). Sizeable proportions (14 percent) of women say they don't know. Differences by background characteristics are not large.

**Table 29\_5.3 Mean ideal number of children**

Mean ideal number of children for ever-married women age 15-49 by background characteristics, Afghanistan 2014

Background characteristic	Mean	Number of women
<b>Age</b>		
15-19	5.6	38
20-24	5.0	200
25-29	5.3	153
30-34	5.9	189
35-39	6.6	186
40-44	6.7	101
45-49	7.2	107
<b>Education</b>		
No education	6.1	845
Primary	5.7	50
Secondary	5.4	68
Higher	*	10
Total	6.0	974

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

**Table 30\_5.4 Couples' family size desires**

Percent distribution of currently married women by whether their husbands want the same, more or fewer children than they do, by background characteristics, Afghanistan 2014

Background characteristic	Both want same	Husband wants more	Husband wants fewer	Don't know	Total	Number of women
<b>Woman's ideal number of children</b>						
1	*	*	*	*	100.0	5
2	(34.2)	(49.5)	(0.0)	(16.3)	100.0	22
3	(58.9)	(17.9)	(1.2)	(22.0)	100.0	21
4	60.4	24.2	3.2	12.2	100.0	244
5	60.4	15.1	5.6	18.8	100.0	99
6+	57.3	20.8	8.2	13.6	100.0	547
<b>Age</b>						
15-19	(68.0)	(20.4)	(0.5)	(11.1)	100.0	37
20-24	61.1	20.8	2.3	15.8	100.0	196
25-29	57.0	23.3	4.2	15.5	100.0	153
30-34	53.8	26.4	8.0	11.8	100.0	185
35-39	55.2	21.6	9.5	13.7	100.0	185
40-44	55.1	17.5	12.0	15.4	100.0	88
45-49	63.2	17.7	5.1	14.0	100.0	94
<b>Education</b>						
No education	57.6	21.5	6.9	14.1	100.0	812
Primary	53.3	16.9	5.8	24.0	100.0	49
Secondary	63.3	26.7	0.4	9.6	100.0	68
Higher	*	*	*	*	100.0	10
Total	57.8	21.8	6.3	14.1	100.0	939

Note: Table excludes women who gave a response of 0 as their ideal number of children. Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 cases that have been suppressed.

## 5.5 Fertility Planning Status

The issue of unplanned and unwanted fertility was investigated in the 2014 AHNS by asking women who had births during the five years before the survey whether the births were wanted at the time (planned), wanted at a later time (mistimed), or not wanted at all (unwanted). The responses to those questions provide a measure of the degree to which couples have been successful in controlling childbearing. In addition, the information can be used to estimate the effect on fertility if unwanted pregnancies had been prevented.

Questions pertaining to the planning status of recent births required the respondent to recall accurately her wishes at one or more points in the past five years and report them honestly. These questions are subject to recall and accuracy bias in remembering how she felt about a particular pregnancy. She also may not be willing to admit that she had not wanted a child at its conception. Conversely, if the child has become an economic or health burden, she may now claim that it was unwanted. Despite these potential problems of comprehension, recall, and truthfulness, results from previous surveys have yielded plausible responses, with the most probable effect of biases in the answers being net underestimation of the level of unwanted fertility.

Table 5.5 shows the distribution of births in the five years before the survey by whether a birth was wanted then, wanted later, or not wanted. Overall, 93 percent of all births were wanted at the time of conception, 3 percent were reported as mistimed (wanted later), and 4 percent were unwanted. The proportion of unwanted births is greater for births that are fourth order or more (7 percent) than for first births, none of which was reported as not wanted at all. Similarly, a much larger proportion of births to older women are unwanted than are those to younger women. Whereas 2 percent of births to women age 20-24 are unwanted, 7 percent of births to women age 35-39 are unwanted, as are 12 percent of births to women age 40-44.

**Table 31\_5.5 Fertility planning status**

Percent distribution of births to women age 15-49 in the five years preceding the survey (including current pregnancies), by planning status of the birth, according to birth order and mother's age at birth, Afghanistan 2014

Birth order and mother's age at birth	Planning status of birth			Total	Number of births
	Wanted then	Wanted later	Wanted no more		
<b>Birth order</b>					
1	96.7	3.3	0.0	100.0	195
2	97.0	1.8	1.1	100.0	171
3	95.9	2.2	2.0	100.0	153
4+	89.5	3.4	7.1	100.0	653
<b>Mother's age at birth</b>					
<20	97.4	2.1	0.4	100.0	152
20-24	95.9	1.8	2.3	100.0	283
25-29	89.3	4.7	6.0	100.0	253
30-34	91.3	4.4	4.3	100.0	194
35-39	89.5	3.4	7.1	100.0	107
40-44	(88.4)	(0.0)	(11.6)	100.0	31
45-49	*	*	*	100.0	3
Total	92.7	3.0	4.4	100.0	1,172

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.



## 5.6 Wanted Fertility Rates

Responses to the question on the ideal number of children can be used to calculate a total “wanted” fertility rate. This measure is calculated in the same manner as the conventional total fertility rate, except that unwanted births are excluded from the numerator. A birth is considered wanted if the number of living children at the time of conception is less than the ideal number of children currently reported by the respondent. Wanted fertility rates express the level of fertility that theoretically would result if all unwanted births were prevented. Comparison of the actual fertility rate with the wanted rate indicates the potential demographic impact of eliminating unwanted births.

Table 5.6 shows that the wanted fertility rate is 4.4 children, compared with the actual fertility rate of 5.2 children (rates calculated over the three years prior to the survey). In other words, women are currently having an average of 0.8 children more than they actually want. The table also shows that except among women with more than secondary schooling, the wanted fertility rate is lower than the actual total fertility rate at all levels of education.

**Table 32\_5.6 Wanted fertility rates**

Total wanted fertility rates and total fertility rates for the three years preceding the survey, by background characteristics, Afghanistan 2014

<b>Education</b>	Total wanted fertility rates	Total fertility rate
No education	4.8	5.6
Primary	3.8	4.4
Secondary	2.6	3.5
Higher	1.0	1.0
Total	4.4	5.2

Note: Rates are calculated based on births to women age 15-49 in the period 1-36 months preceding the survey. The total fertility rates are the same as those presented in Table 4.2.

**Key Findings**

- Knowledge of contraception is nearly universal in the program areas: 97 percent of currently married women have heard of at least one method and 91 percent have heard of two or more contraceptive methods.
- Currently married women have heard of an average of 4 contraceptive methods
- The contraceptive prevalence rate shows that only 18 percent of currently married women are using some method, almost all modern methods (17 percent).
- Among married women, the contraceptive method that is by far the most commonly used is the injectable (14 percent).
- Almost all modern contraceptive users obtain their methods from the public sector (96 percent). Government health centers are the most common public source (52 percent), followed by government hospitals (29 percent).

**F**amily planning refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptives. This chapter presents results from the 2014 AHNS on a number of aspects of contraception: knowledge of specific contraceptive methods, current use, sources of current contraceptive methods, payment for services, and reasons for non-use. For most tables, the focus is on currently married women because these women have the greatest risk of exposure to pregnancy and therefore the greatest need for regulating their fertility.

### 6.1 Knowledge of Contraceptive Methods

Information about contraceptive methods was collected by asking ever-married women if they had heard of various methods that a couple can use to delay or avoid a pregnancy. Specifically, the interviewer named a method, described it, and then asked whether the woman had heard of it. In all, the interviewer asked about nine different contraceptive methods. Provision was also made in the questionnaire to record any additional methods the respondent had heard of but was not asked about by the interviewer.

Contraceptive methods are classified into two broad categories, namely modern methods and traditional methods. Modern methods include female sterilization, the pill, the intrauterine device (IUD), injectables, implants, condoms, and emergency contraception. Traditional methods include rhythm (periodic abstinence) and withdrawal.

Table 6.1 shows that knowledge of at least some contraceptive method is almost universal in the program areas in Afghanistan, with 97 percent of currently married women knowing at least one method of contraception. Modern methods are more widely known than traditional methods; 97 percent of currently married women know of a modern method, while 31 percent know of a traditional method.

Married women have heard of an average of 4.0 contraceptive methods. The pill, injectables, and condoms are the contraceptive methods most widely known by women. Among currently married women age 15-49, 85 percent have heard of the pill, 78 percent have heard of injectables, and 58 percent have heard of condoms. Knowledge of several other modern methods is somewhat lower. For example, 49 percent of women have heard of the IUD, 37 percent know about female sterilization, and 30 percent know about implants. Knowledge of emergency contraception is not very widespread (18 percent). Less than one-quarter of currently married women know about withdrawal, while 20 percent have heard of the rhythm method.

Knowledge of contraceptive methods is almost the same among currently married women and ever-married women. This is because almost all of the women who have ever been married are currently married.

Knowledge of at least one contraceptive method is uniformly high among currently married women in all categories of background characteristics (Table 6.2). For example, by age group, the percentage of currently married women who know at least one modern family planning method is 93-99 percent. More than 9 in 10 married women know of at least two methods.

**Table 33\_6.1 Knowledge of contraceptive methods**

Percentage of ever-married and currently married women age 15-49 who know any contraceptive method, by specific method, Afghanistan 2014

Method	Ever-married women	Currently married women
<b>Any method</b>	96.3	96.6
<b>Any modern method</b>	96.3	96.5
Female sterilization	36.2	36.8
Pill	84.6	84.7
IUD	48.1	48.8
Injectables	76.7	77.5
Implants	30.2	30.4
Male condom	58.1	58.2
Emergency contraception	18.4	18.4
<b>Any traditional method</b>	30.8	30.5
Rhythm	20.1	19.7
Withdrawal	23.9	23.7
Mean number of methods known	4.0	4.0
<b>Number of respondents</b>	974	943

**Table 34\_6.2 Knowledge of contraceptive methods by background characteristics**

Percentage of currently married women age 15-49 who have heard of at least one contraceptive method and who have heard of at least one modern method by background characteristics, Afghanistan 2014

Background characteristic	Heard of any method	Heard of any modern method <sup>1</sup>	Heard of two or more methods	Heard of two or more modern methods <sup>1</sup>	Number
<b>Age</b>					
15-19	95.0	95.0	90.6	90.6	38
20-24	97.1	97.1	95.1	94.4	198
25-29	98.1	98.1	94.0	93.1	153
30-34	98.7	98.7	92.0	90.9	185
35-39	95.0	94.7	89.1	88.7	185
40-44	96.8	96.8	80.9	77.7	89
45-49	92.8	92.8	87.6	87.6	94
<b>Education</b>					
No education	96.3	96.2	89.8	88.9	815
Primary	98.8	98.8	97.5	97.5	49
Secondary	98.5	98.5	97.2	95.6	68
Higher	*	*	*	*	10
Total 15-49	96.6	96.5	90.8	90.0	943

<sup>1</sup> Female sterilization, pill, IUD, injectables, implants, male condom, and emergency contraception.

## 6.2 Current Use of Contraception

Contraceptive use is one of the principal determinants of fertility. Measures of current use of contraceptive methods are a prominent means of gauging the coverage of reproductive health programs. To obtain information on current use of contraception, all currently married women interviewed in the AHNS who were not pregnant at the time of the survey were asked if they (or their partners) were currently using a method. Table 6.3 shows the level of current contraceptive use among currently married women by age group.

The contraceptive prevalence rate (CPR), or the percentage of currently married women who use a contraceptive method, is 18 percent, while the CPR for modern contraceptive methods is 17 percent (Figure 6.1). Among currently married women, the contraceptive method that is by far the most commonly used is the injectable (14 percent). The other modern methods used by currently married women are pills (3 percent) and condoms (1 percent). Less than 1 percent of currently married women use the IUD or traditional methods.

The use of contraceptive methods among currently married women generally increases with age, from 8-10 percent of those age 15-24 to 21-25 percent of those age 30-44, before decreasing to 19 percent of those ages 45-49. Patterns of use by age vary, depending on the method. Use of injectables tends to rise with age up to age 30-34 and then falls. Use of the pill is rather erratic by age group. Use of condoms is highest among the youngest women age 15-19.

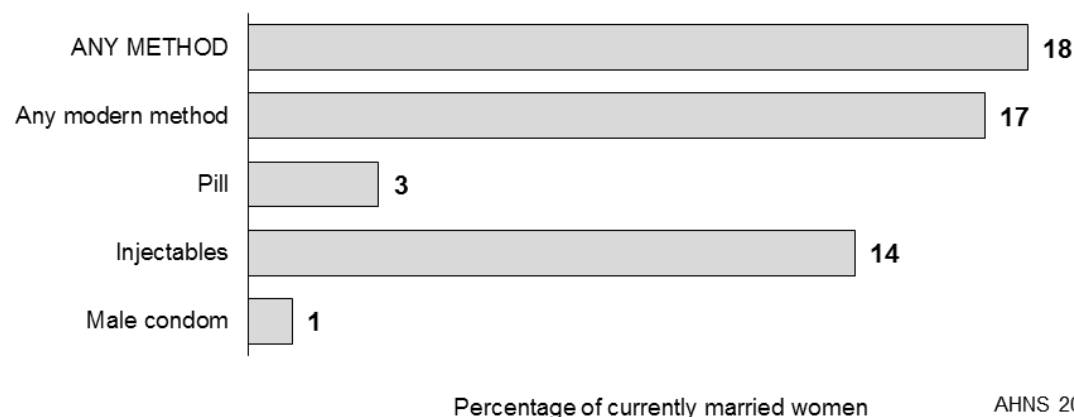
**Table 35\_6.3 Current use of contraception by age**

Percent distribution of all women, currently married women age 15-49 by contraceptive method currently used, according to age, Afghanistan 2014

Age	Any method	Any modern method	Pill	Modern method			Any traditional method	Not currently using	Total	Number of women
				IUD	Injectables	Male condom				
15-19	9.7	9.7	0.0	0.2	6.0	3.5	0.0	90.3	100.0	38
20-24	8.1	8.1	4.2	0.2	2.3	1.3	0.0	91.9	100.0	198
25-29	12.9	12.2	1.9	0.1	10.1	0.0	0.7	87.1	100.0	153
30-34	25.2	25.2	2.1	0.0	23.1	0.0	0.0	74.8	100.0	185
35-39	21.3	21.3	3.9	0.2	17.1	0.1	0.0	78.7	100.0	185
40-44	25.3	25.3	5.1	1.3	18.5	0.3	0.0	74.7	100.0	89
45-49	18.6	18.6	3.6	0.1	14.6	0.2	0.0	81.4	100.0	94
Total	17.6	17.4	3.2	0.2	13.5	0.5	0.1	82.4	100.0	943

Note: If more than one method is used, only the most effective method is considered in this tabulation.

**Figure 3\_6.1 Contraceptive Use among Currently Married Women**



### 6.3 Current Use of Contraception by Background Characteristics

Table 6.4 presents information on current use of contraceptives among currently married women age 15-49. Current use of any method of contraception varies by number of living children and education. No currently married women without children use a contraceptive method, while over one-quarter of married women with five or more children use a contraceptive method. The level of contraceptive use declines as education level increases. For example, 19 percent of currently married women with no education are using a contraceptive method, compared with only 7 percent of those with some secondary schooling.

**Table 36\_6.4 Current use of contraception by background characteristics**

Percent distribution of currently married women age 15-49 by contraceptive method currently used, according to background characteristics, Afghanistan 2014

Background characteristic	Any method	Any modern method	Modern method				Any traditional method	Not currently using	Total	Number of women
			Pill	IUD	Injectables	Male condom				
<b>Number of living children</b>										
0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0	86
1-2	8.9	8.4	3.9	0.2	3.1	1.2	0.5	91.1	100.0	230
3-4	17.3	17.3	3.5	0.1	13.2	0.5	0.0	82.7	100.0	225
5+	26.4	26.4	3.4	0.4	22.4	0.2	0.0	73.6	100.0	402
<b>Education</b>										
No education	18.5	18.4	3.5	0.2	14.3	0.4	0.1	81.5	100.0	815
Primary	16.4	16.4	1.9	0.2	12.1	2.2	0.0	83.6	100.0	49
Secondary	7.2	7.2	0.7	0.9	5.2	0.4	0.0	92.8	100.0	68
Higher	*	*	*	*	*	*	*	*	100.0	10
Total	17.6	17.4	3.2	0.2	13.5	0.5	0.1	82.4	100.0	943

Note: If more than one method is used, only the most effective method is considered in this tabulation. An asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

### 6.4 Source of Modern Contraceptive Methods

Where women obtain the contraceptive methods they use is useful information for family planning program managers and others who plan the distribution of contraceptives. In the 2014 AHNS, women who reported that they were using any modern contraceptive method at the time of the survey were asked where they obtained the method the last time they acquired it. Table 6.5 shows that almost all users (96 percent) obtain their contraceptives from public sector sources. Government health centers are the most common source (52 percent), followed by government hospitals (29 percent). Fourteen percent of users get their method from a government mobile clinic. Only 4 percent of users say that they get their method from a private sector source, mostly pharmacies.

**Table 37\_6.5 Source of modern contraception methods**

Percent distribution of current users of modern contraceptive methods age 15-49 by most recent source of the method, according to method, Afghanistan 2014

Source	Pill	Injectables	Total
<b>Public sector</b>	(82.7)	98.4	95.5
Government hospital	(24.2)	27.7	28.7
Government health center	(53.1)	53.4	52.4
Mobile clinic	(5.4)	17.3	14.3
<b>Private medical sector</b>	(12.6)	1.6	3.6
Private hospital or clinic	(0.0)	0.0	0.1
Pharmacy	(12.0)	0.1	2.3
Private doctor	(0.0)	0.7	0.6
Mobile clinic	(0.3)	0.0	0.1
Community health worker	(0.3)	0.8	0.7
<b>Other source</b>	(4.7)	0.0	0.9
Shop/Bazaar	(4.7)	0.0	0.9
Total	100.0	100.0	100.0
Number of women	30	127	164

Note: Total includes other modern methods. Figures in parentheses are based on 25-49 unweighted cases.

## 6.5 Informed Choice

Women age 15-49 who were using a modern contraceptive method at the time of the survey were asked whether they had ever been informed about possible side effects or problems of their chosen method and about other methods that they could use. Their responses give a measure of the quality of family planning service provision. Table 6.6 shows the results by method and by source of the method.

About two-thirds (68 percent) of users of modern contraceptives were informed about side effects or health problems associated with the method they used and 61 percent were told of other methods available. Since the vast majority of modern method users are using injectables, the data are similar for those users. Differences in informed choice by source of method are difficult to assess due to the small number of users for most sources.

**Table 38\_6.6 Informed choice**

Among current users of modern methods age 15-49 the percentage who were ever informed about possible side effects or problems, of that method and the percentage who were ever informed about other methods they could use, by method and initial source, Afghanistan 2014

<u>Method/source</u>	<u>Percentage who were informed about side effects or problems of method used</u>	<u>Percentage who were informed by a health or family planning worker of other methods that could be used</u>	<u>Number of women</u>
<b>Method</b>			
Pill	(55.0)	(52.0)	30
IUD	*	*	2
Injectables	71.8	63.0	127
<b>Initial source of method<sup>1</sup></b>			
Public sector	67.9	62.4	152
Government hospital	(58.3)	(51.1)	43
Government health center	70.6	65.5	86
Mobile clinic	*	*	24
Private medical sector	*	*	12
Other source	*	*	1
Total	68.0	61.1	160

Note: Table includes users of only the methods listed individually. Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

<sup>1</sup> Source at start of current episode of use

## 6.6 Payment for Family Planning

Women interviewed in the 2014 AHNS who said they were using a modern method of family planning were asked whether they paid for the method the last time they obtained it or whether they had gotten it free of charge. As shown in Table 6.7, just under one in four users pay for their methods (23 percent), while about 3 in 4 do not (77 percent). Women who use the pill are more likely than average to pay for their method. Since almost all users are using injectables and since almost all injectables users get their method from a public source, there are too few cases for other sources to provide any meaningful results about payment according to source of the method.

**Table 39\_6.7 Payment for family planning methods**

Among current users of modern methods age 15-49, percent distribution by whether they paid for the method or got it free of charge the last time they obtained it, by method and type of source, Afghanistan 2014

<u>Background characteristic</u>	<u>Paid money</u>	<u>Got free</u>	<u>Total</u>	<u>Number of women</u>
<b>Method</b>				
Pill	(34.1)	(65.9)	100.0	30
IUD	*	*	100.0	2
Injectables	21.2	78.8	100.0	127
Condoms	*	*	100.0	5
<b>Most recent source of method</b>				
Public sector	20.5	79.5	100.0	157
Private medical sector	*	*	100.0	6
Other private sector	*	*	100.0	1
Total	23.3	76.7	100.0	164

Note: Numbers in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

## 6.7 Knowledge of a Source for Family Planning

In the 2014 AHNS, currently married women who were not using a method of family planning were asked if they knew of a place to get a method. As shown in Table 6.8, only 60 percent of married women said they knew a place. Thus, two in five married women said they did not know where to get a family planning method. It is possible that many of these were young women who were embarrassed to admit to an interviewer that they know a source.

**Table 40\_6.8 Knowledge of a family planning source**

Percent distribution of currently married women who are not using contraception by whether they know of a place to obtain a method of family planning, Afghanistan 2014

<u>Knowledge of a source</u>	<u>Total</u>
No	40.4
Yes	59.6
Total	100.0
Number of women	777

## Key Findings

- Only 46 percent of women age 15-49 who gave birth in the five years preceding the survey received antenatal care from a skilled provider during pregnancy for their most recent birth. Twenty percent of women received antenatal care during their first trimester.
- Forty-six percent of women with a recent birth took iron supplements during the pregnancy.
- Of the less than half of women who received antenatal care, three-quarters were informed of signs of pregnancy complications and half reported that they had their blood pressure measured.
- More than half of births are protected against tetanus.
- Forty-three percent of births take place in a health facility and 45 percent are assisted by a skilled provider.
- Among women who gave birth in the two years preceding the survey, only 38 percent of the women and 8 percent of their newborns received a postnatal checkup within the first two days after birth.

The health care services that a mother receives during pregnancy, childbirth, and the immediate postnatal period are important for the survival and wellbeing of both the mother and the infant. The 2014 AHNS obtained information on the extent to which women in the CAHSS program areas receive care during each of these stages. These results are important to those who design policy and implement programs to improve maternal and child health care services.

## 7.1 Antenatal Care

Antenatal care from a skilled provider is important to monitor pregnancy and reduce the risks for both mother and child during pregnancy, at delivery and within the postnatal period (within 42 days after delivery). Antenatal care enables (1) screening and/or early detection of complications and prompt treatment (e.g., of sexually transmitted infections or anemia); (2) prevention of diseases through immunization and micronutrient supplementation; (3) birth preparedness and complication readiness; (4) health promotion and disease prevention through health messages; and (5) advice and counseling of pregnant women, including place of delivery and referral of mothers with complications.

Collecting information on antenatal care is relevant for identifying subgroups of women who do not use such services and is useful in planning improvements in services provided. In the AHNS, women who had given birth in the five years preceding the survey were asked whether they had received antenatal care for their last live birth. If the respondent had received antenatal care for her last birth, she was then asked a series of questions about the care she received, such as the type of provider, number of visits made, stage of pregnancy at the time of the first visit, and services and information provided during these visits. For women with two or more live births during the five-year period preceding the survey, data refer to the most recent birth. For women who reported more than one source of antenatal services, only the provider with the highest qualifications is considered.

Table 7.1 presents information about the type of provider from whom antenatal care services were received for the most recent birth, according to background characteristics. It shows that less than half (46 percent) of women age 15-49 who had a live birth in the five years preceding the survey received antenatal



care from a skilled provider (doctor, nurse, midwife, or auxiliary midwife) during their last pregnancy. More women received care from a doctor (29 percent) than from a nurse or midwife (16 percent), while very few received antenatal care from auxiliary midwives, traditional birth attendants, and community health workers. Over half of women did not receive any antenatal care.

**Table 41\_7.1 Antenatal care**

Percent distribution of women age 15-49 who had a live birth in the five years preceding the survey by antenatal care (ANC) provider during pregnancy for the most recent birth and the percentage receiving antenatal care from a skilled provider for the most recent birth, according to background characteristics, Afghanistan 2014

Background characteristic	Antenatal care provider					No ANC	Total	Percentage receiving antenatal care from a skilled provider <sup>1</sup>	Number of women
	Doctor	Nurse/ midwife	Auxiliary midwife	Traditional birth attendant	Community/ village health worker				
<b>Mother's age at birth</b>									
<20	37.6	21.0	0.0	0.0	0.9	40.4	100.0	58.6	92
20-34	28.2	14.9	1.3	0.3	1.6	53.7	100.0	44.4	459
35-49	23.5	14.3	1.9	1.1	4.0	55.3	100.0	39.6	122
<b>Birth order</b>									
1	32.9	18.1	0.0	0.0	0.7	48.2	100.0	51.0	104
2-3	31.3	13.5	1.8	0.0	3.6	49.8	100.0	46.6	164
4-5	24.0	17.3	0.9	0.9	1.1	55.8	100.0	42.2	167
6+	28.2	14.8	1.5	0.6	1.9	52.9	100.0	44.6	239
<b>Education</b>									
No education	29.4	15.1	1.4	0.5	2.0	51.5	100.0	45.9	586
Primary	14.8	6.7	0.0	0.0	2.8	75.7	100.0	21.5	35
Secondary	30.3	28.1	0.2	0.0	0.4	41.1	100.0	58.5	47
Higher	*	*	*	*	*	*	100.0	*	4
Total	28.7	15.6	1.2	0.4	1.9	52.2	100.0	45.5	673

Note: If more than one source of ANC was mentioned, only the provider with the highest qualifications is considered in this tabulation. An asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

<sup>1</sup> Skilled provider includes doctor, nurse, midwife, and auxiliary nurse/midwife

There are differences by background characteristics in the percentage of women who receive antenatal care from a skilled provider. For example, the proportion with skilled antenatal care decreases as age of the mother increases. It also tends to decrease with increasing birth order. The relationship between education of the woman and the prevalence of antenatal care from a skilled provider is not consistent, being highest for those with only secondary education, but next highest for women with no education and lowest for those with primary school only.

## 7.2 Number and Timing of Antenatal Visits

Antenatal care is more effective in preventing adverse pregnancy outcomes when sought early in the pregnancy and continued through to delivery. Health professionals recommend that the first antenatal visit occur within 12 to 16 weeks of pregnancy. The second visit should occur at 28 weeks, the third visit at 32 weeks, and the fourth visit at 36 weeks. Under normal circumstances, WHO recommends that a woman without complications should have at least four visits. Women with complications, special needs, or conditions beyond the scope of basic care may require additional visits.

In the AHNS, respondents were asked how many antenatal care visits they made during the pregnancy preceding their last live birth in the five years before the survey and how many months pregnant they were at the time of the first visit. Table 7.2 shows that among women who had a live birth in the five years preceding the survey, 21 percent had four or more antenatal care visits, 23 percent had two to three visits, and 4 percent had only one visit. As mentioned above, over half of women had no antenatal care.

Table 7.2 also shows that only one-fifth of women (20 percent) had their first visit at less than four months of pregnancy, as recommended. Seventeen percent of women had their first visit in the fourth to the fifth month of pregnancy, and 8 percent had their first visit in the sixth to the seventh month of pregnancy. The median duration of pregnancy at the first visit was 4.3 months.

### 7.3 Components of Antenatal Care

The content of antenatal care is an essential component of the quality of services. Apart from receiving basic care, every pregnant woman should be monitored for complications. Ensuring that pregnant women receive information on and undergo screening for complications should be a routine part of all antenatal care visits. To assess antenatal care services, respondents were asked whether they had been advised of complications or received certain screening tests during at least one of the antenatal care visits. Table 7.3 presents information on the content of antenatal services, including the percentages of women who took iron supplements, were informed of the signs of pregnancy complications, and received selected routine services during antenatal care visits for their most recent birth in the past five years.

Overall, 46 percent of women took iron tablets during the pregnancy of their last birth. Variations by background characteristics are generally minor.

Three-quarters of the women who received antenatal care for their most recent live birth in the five years preceding the survey were informed of the signs of pregnancy complications and half reported that they had their blood pressure measured. Over one-third of women who received antenatal care for a birth in the five years before the survey had a urine sample taken and 42 percent had a blood sample taken. Coverage for most of these antenatal care services tends to decrease as birth order increases. Differences by mother's age at birth and education are difficult to interpret, given the low percentage of women who receive antenatal care (46 percent).

**Table 42\_7.2 Number of antenatal care visits and timing of first visit**

Percent distribution of women age 15-49 who had a live birth in the five years preceding the survey by number of antenatal care (ANC) visits for the most recent live birth, and by the timing of the first visit, and among women with ANC, median months pregnant at first visit, according to residence, Afghanistan 2014

Number and timing of ANC visits	Total
<b>Number of ANC visits</b>	
None	52.2
1	3.6
2-3	22.6
4+	21.0
Don't know/missing	0.7
Total	100.0
<b>Number of months pregnant at time of first ANC visit</b>	
No antenatal care	52.2
<4	20.2
4-5	16.6
6-7	8.3
8+	1.7
Don't know/missing	1.0
Total	100.0
Number of women	673
Median months pregnant at first visit (for those with ANC)	4.3
Number of women with ANC	322

**Table 43\_7.3 Components of antenatal care**

Among women age 15-49 with a live birth in the five years preceding the survey, the percentage who took iron tablets or syrup during the pregnancy of the most recent birth and among women receiving antenatal care (ANC) for the most recent live birth in the five years preceding the survey, the percentage receiving specific antenatal services, according to background characteristics, Afghanistan 2014

Background characteristic	Among women with a birth in the past five years, the percentage who during the pregnancy of their last birth:		Among women who received antenatal care for their most recent birth in the past five years, the percentage with selected services				
	Took iron tablets or syrup	Number of women with a live birth in the past five years	Informed of signs of pregnancy complications	Blood pressure measured	Urine sample taken	Blood sample taken	Number of women with ANC for their most recent birth
<b>Mother's age at birth</b>							
<20	47.3	92	(82.8)	(57.0)	(41.2)	(45.3)	55
20-34	47.3	459	74.1	46.4	34.9	37.2	213
35-49	41.7	122	(64.1)	(64.2)	(31.5)	(55.1)	54
<b>Birth order</b>							
1	49.4	104	84.2	51.5	49.4	44.7	54
2-3	48.7	164	66.8	63.0	36.3	41.1	82
4-5	50.6	167	76.9	46.1	36.5	40.6	74
6+	40.1	239	72.1	45.8	27.4	41.2	112
<b>Education</b>							
No education	45.3	586	72.7	48.8	34.4	40.9	284
Primary	60.9	35	(93.9)	(86.4)	(37.2)	(59.1)	9
Secondary	47.3	47	(79.5)	(63.1)	(45.3)	(42.8)	28
Higher	*	4	*	*	*	*	2
Total	46.3	673	73.9	51.2	35.4	41.6	322

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

## 7.4 Knowledge about Danger Signs in Pregnancy

Although timely antenatal care can reduce problems in pregnancy and delivery, knowledge of danger signs is also important in encouraging pregnant women to seek help. In the AHNS, women who had a birth in the five years before the survey were asked what signs would indicate that a pregnant woman should seek health care immediately. Although the question was open-ended, the questionnaire contained a pre-coded list of likely answers and it is unclear whether interviewers might have read the list to respondents. Table 7.4 shows the proportion of all ever-married women and of ever-married women who had a birth in the five years before the survey who mention each danger sign.

Vaginal bleeding is the most commonly mentioned danger sign of pregnancy, with almost four in five women citing it, regardless of whether or not they had a birth in the five years before the survey. The next most commonly mentioned danger sign is vaginal discharge of fluids, mentioned by 44-

**Table 44\_7.4 Knowledge of danger signs during pregnancy**

Among all ever-married women age 15-49 and ever-married women age 15-49 with a birth in the five years before the survey, percentage who mention specific danger signs that indicate that a pregnant woman should seek immediate medical care, Afghanistan 2014

Danger sign	All ever-married women	Ever-married women with a birth in the five years before the survey
Bleeding from the vagina	79.2	78.1
Strong headache/dizziness	21.5	21.9
Baby doesn't move	31.0	30.4
Water from the vagina	44.2	45.3
Fever	28.3	29.7
Convulsions/Fits	15.5	17.8
Strong pain in abdomen	38.6	36.6
Swelling in face or abdomen	34.6	35.9
Continuous strong vomiting	24.4	26.4
Blurry vision	9.6	10.7
Percent knowing 3+	70.7	72.5
Number of women	974	673

45 percent of women. About one-third of women each mention strong abdominal pain, swelling in the face or abdomen, lack of movement of the baby, and fever as signs that a pregnant woman should seek immediate medical care. Continuous, strong vomiting is mentioned by about one-quarter of women, while strong headaches or dizziness are mentioned by about one-fifth of women. Convulsions and fits are mentioned by 16-18 percent of women and blurry vision by about 10 percent of women. Responses from all ever-married women and those who had a birth in the five years before the survey are remarkably similar. More than 7 in 10 women mentioned three or more signs.

## 7.5 Tetanus Toxoid Injections

Tetanus toxoid injections are given during pregnancy to prevent neonatal tetanus, a leading cause of early infant death in many developing countries that is often due to poor hygiene during delivery. For full protection of her newborn baby, a pregnant woman should receive at least two injections of the vaccine during the pregnancy. If a woman has been vaccinated during a previous pregnancy, however, she may only require one or no doses for the current pregnancy. Five doses are considered to provide lifetime protection. Among women age 15-49 with a live birth in the five years preceding the survey, Table 7.5 presents the percentage of mothers whose last birth was protected against neonatal tetanus.

**Table 45\_7.5 Tetanus toxoid injections**

Among mothers age 15-49 with a live birth in the five years preceding the survey, the percentage receiving two or more tetanus toxoid injections during the pregnancy for the last live birth and the percentage whose last live birth was protected against neonatal tetanus, according to background characteristics, Afghanistan 2014

Background characteristic	Percentage receiving two or more injections during last pregnancy	Percentage whose last birth was protected against neonatal tetanus <sup>1</sup>	Number of mothers
<b>Mother's age at birth</b>			
<20	37.9	50.2	91
20-34	37.6	55.2	457
35-49	34.7	51.5	119
<b>Birth order</b>			
1	49.3	65.8	101
2-3	36.0	57.1	164
4-5	37.5	50.8	166
6+	32.4	48.7	236
<b>Education</b>			
No education	33.9	51.0	581
Primary	57.8	59.0	35
Secondary	60.3	82.5	47
Higher	*	*	4
Total	37.1	53.9	667

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

<sup>1</sup> Includes mothers with two injections during the pregnancy of her last birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections at any time prior to the last birth.

Only 37 percent of women received two or more tetanus toxoid injections during the pregnancy of their last live birth. Women are more likely to have received two or more tetanus toxoid injections during the last pregnancy for their first birth than for subsequent births. The proportion of women who received

two or more tetanus toxoid injections during pregnancy are higher for those with some education than for those with no education.

Overall, 54 percent of women's last births were protected against neonatal tetanus. Differences by background characteristics follow similar patterns to those reported for women who received two or more tetanus toxoid injections during the last pregnancy. Notably, 83 percent of births to mothers with at least some secondary education are protected against tetanus.

## 7.6 Birth Preparedness

Adequate birth planning can help save lives and reduce illness. In the AHNS, women who had a live birth in the five years before the survey were asked several questions about the most recent birth. Specifically, they were asked if, towards the end of the pregnancy, they planned which hospital they might go to in case of an emergency, whether they arranged for transport to get to this hospital, and whether they had set aside funds in case of an emergency. Finally, they were also asked if they had prepared clothes for the newborn baby. Table 7.6 shows the results according to background characteristics of the mother and baby.

**Table 46\_7.6 Birth preparedness**

Among women age 15-49 with a live birth in the five years preceding the survey, the percentage who planned for which hospital to go to in an emergency, who arranged for transport to get to a hospital, who set aside funds in case of an emergency, and who prepared clothes for the baby towards the end of the pregnancy for the most recent live birth in the five years preceding the survey, according to background characteristics, Afghanistan 2014

Background characteristic	Among women with a live birth in the past five years, the percentage who during the pregnancy for their last birth				Number of women with a live birth in the past five years
	Planned for which hospital to go to in case of emergency	Arranged for transport to get to a hospital	Set aside funds in case of emergency	Prepared clothes for the baby	
<b>Mother's age at birth</b>					
<20	57.9	54.4	48.2	79.0	91
20-34	53.3	44.6	42.6	71.7	457
35-49	33.9	32.2	23.6	61.9	119
<b>Birth order</b>					
1	59.1	54.5	57.3	84.0	101
2-3	55.3	46.7	40.5	63.7	164
4-5	51.9	45.6	44.5	74.6	166
6+	42.3	35.6	29.0	67.8	236
<b>Education</b>					
No education	49.9	43.1	38.7	72.0	581
Primary	56.1	47.4	52.6	57.7	35
Secondary	51.3	45.7	44.2	68.9	47
Higher	*	*	*	*	4
Total	50.4	43.7	40.0	71.0	667

Note: an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

Results show a moderate level of birth preparedness. Half of women who gave birth in the five years before the survey said that for their most recent birth, they had planned which hospital to go to in an emergency, while 40-44 percent had arranged transport and had set aside emergency funds. Seventy-one percent of mothers said they had prepared clothes for the baby.

Older mothers are less likely to have complied with each of the four indicators of preparedness than younger mothers. Similarly, mothers who gave birth to sixth or higher order children are generally less likely to have met each of the four indicators than mothers with fewer children.

## 7.7 Place of Delivery

Increasing the proportion of women who deliver in health facilities is an important factor in reducing health risks to the mother and the newborn. Proper medical attention and hygienic conditions during delivery can reduce the risks of complications and infections that can cause morbidity and mortality to either the mother or the infant. Table 7.7 presents the percent distribution of live births in the five years preceding the survey by place of delivery, according to background characteristics.

The results show that fewer than half of births (43 percent) in the program areas occurred in health facilities, almost all of which were government facilities. Fifty-seven percent of births are delivered at home. Births to women under age 20 years and first births are much more likely to be delivered in a health facility than births to older women or births of a higher order. As might be expected, the proportion of births delivered in a health facility increases with the number of antenatal care visits a woman had.

**Table 47\_7.7 Place of delivery**

Percent distribution of live births in the five years preceding the survey by place of delivery and percentage delivered in a health facility, according to background characteristics, Afghanistan 2014

Background characteristic	Health facility			Total	Percentage delivered in a health facility	Number of births
	Public sector	Private sector	Home			
<b>Mother's age at birth</b>						
<20	67.8	1.7	30.4	100.0	69.6	151
20-34	38.8	0.2	60.9	100.0	39.1	728
35-49	32.6	0.0	67.4	100.0	32.6	140
<b>Birth order</b>						
1	64.8	1.3	33.9	100.0	66.1	166
2-3	45.3	0.6	54.0	100.0	46.0	282
4-5	34.4	0.0	65.6	100.0	34.4	255
6+	33.9	0.1	65.9	100.0	34.1	315
<b>Antenatal care visits<sup>1</sup></b>						
None	30.7	0.0	69.3	100.0	30.7	346
1-3	49.4	1.3	49.3	100.0	50.7	176
4+	75.7	0.6	23.8	100.0	76.2	141
<b>Mother's education</b>						
No education	41.8	0.4	57.8	100.0	42.2	889
Primary	48.2	0.0	51.8	100.0	48.2	52
Secondary	41.4	1.2	57.4	100.0	42.6	69
More than secondary	*	*	*	100.0	*	9
Total	42.3	0.4	57.3	100.0	42.7	1,018

Note: an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed. Total includes 5 births missing information as to the number of antenatal care visits.

<sup>1</sup> Includes only the most recent birth in the five years preceding the survey

Women who did not deliver their most recent birth in the five years before the survey in a health facility were asked why they did not utilize a facility. As shown in Table 7.8, the most common reasons for delivering at home are that the baby came early (45 percent) and that the facility was far away or there was no transport (42 percent). Cost was a factor mentioned by 28 percent of women who did not deliver in a health facility. One-fifth of women said that facility-based deliveries are not necessary and 16 percent said they are not customary. Fourteen percent of women who delivered at home cited family refusal as a reason why they did not deliver in a facility. Characteristics of the health facility such as not being open, having no female provider, or being of poor quality, were not mentioned by sizable proportions of women as reasons for not delivering in a facility.

**Table 48\_7.8 Reasons for not delivering in a health facility**

Among mothers age 15-49 whose last live birth in the five years preceding the survey was not delivered in a health facility, percentage who cite specific reasons for not delivering in a facility, Afghanistan 2014

Reason	Percentage	Number of mothers
Cost too much	28.3	165
Facility not open	8.2	48
Far, no transport	41.5	242
Do not trust facility/poor quality	2.5	15
No female provider	3.6	21
Family refused	14.1	82
Not necessary	21.2	123
Not customary	16.2	94
Baby came early	45.0	263
Other	0.1	1
Total	na	584

## 7.8 Assistance during Delivery

Obstetric care from a skilled provider (doctor, nurse, midwife, or auxiliary midwife) during delivery is recognized as a critical element in the reduction of maternal and neonatal mortality. Births delivered at home are usually more likely to be delivered without assistance from a skilled provider, whereas births delivered at a health facility are more likely to be delivered by a trained health professional. Table 7.9 shows the percent distribution of live births in the five years preceding the survey by person providing assistance at delivery and the percentage of births delivered by Caesarean section (C-section), according to background characteristics.

Less than half of live births in the five years preceding the survey were delivered by a skilled provider, with 23 percent of the deliveries assisted by a doctor and 22 percent by a nurse, midwife, or auxiliary midwife. The same proportion (22 percent) was assisted by traditional birth attendants. Almost one-third of births were assisted by only relatives or friends.

The percentage of live births delivered by a skilled provider decreases consistently as both age of the mother and the birth order increase. As expected, skilled assistance at delivery is almost universal for births that take place in a health facility and it also increases as the number of antenatal care visits increases.

Respondents were also asked whether each of their live births in the five years preceding the survey was delivered by Caesarean (C-section). Overall, 3 percent of births were delivered by C-section.

Table 49\_7.9 Assistance during delivery

Percent distribution of live births in the five years preceding the survey by person providing assistance during delivery, percentage of birth assisted by a skilled provider and percentage delivered by caesarean-section, according to background characteristics, Afghanistan 2014

Background characteristic	Person providing assistance during delivery							Total	Percentage delivered by a skilled provider <sup>1</sup>	Percentage delivered by C-section	Number of births
	Doctor	Nurse/ midwife	Auxiliary midwife	Traditional birth attendant	Relative/ friend	Other	No one				
<b>Mother's age at birth</b>											
<20	31.2	34.5	0.6	12.6	21.0	0.0	0.0	100.0	66.3	6.5	152
20-34	22.9	17.9	1.5	20.7	36.2	0.7	0.1	100.0	42.3	3.1	730
35-49	16.9	20.2	1.1	38.4	23.1	0.0	0.3	100.0	38.2	0.8	142
<b>Birth order</b>											
1	30.0	32.4	0.6	14.0	21.9	1.1	0.0	100.0	63.0	5.9	169
2-3	27.7	19.8	2.0	21.9	27.2	1.3	0.1	100.0	49.5	5.5	282
4-5	19.0	19.2	1.8	21.2	38.7	0.0	0.0	100.0	40.1	1.4	257
6+	19.3	16.5	0.6	26.8	36.6	0.0	0.1	100.0	36.4	1.4	317
<b>Antenatal care visits<sup>1</sup></b>											
None	14.4	17.9	1.4	30.5	35.6	0.0	0.2	100.0	33.7	1.6	351
1-3	25.4	24.0	1.9	22.5	26.3	0.0	0.0	100.0	51.2	6.8	176
4+	45.8	31.8	1.0	7.7	13.8	0.0	0.0	100.0	78.5	8.4	141
<b>Place of delivery</b>											
Health facility	49.9	45.0	2.3	0.9	1.9	0.0	0.0	100.0	97.2	7.7	437
Elsewhere	3.6	2.7	0.5	37.6	54.6	0.9	0.1	100.0	6.8	0.0	588
<b>Mother's education</b>											
No education	23.5	20.3	1.5	22.2	31.8	0.6	0.1	100.0	45.3	2.8	895
Primary	26.6	20.7	0.0	28.4	24.3	0.0	0.0	100.0	47.3	1.9	52
Secondary	14.5	27.0	0.1	14.8	43.6	0.0	0.0	100.0	41.6	10.0	69
More than secondary	*	*	*	*	*	*	*	100.0	*	*	9
Total	23.3	20.7	1.3	21.9	32.1	0.5	0.1	100.0	45.3	3.3	1,024

Note: If the respondent mentioned more than one person attending during delivery, only the most qualified person is considered in this tabulation. Total includes 5 births missing information about antenatal care visits.

<sup>1</sup> Skilled provider includes doctor, nurse, midwife and auxiliary midwife.

<sup>2</sup> Includes only the most recent birth in the five years preceding the survey

## 7.9 Postnatal Care For the Mother

A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Thus, prompt postnatal care (PNC) for both the mother and the child is important to treat any complications arising from the delivery, as well as to provide the mother with important information on how to care for herself and her child. Safe motherhood programs recommend that all women receive a check of their health within two days after delivery. Women who deliver at home should go to a health facility for postnatal care services within 24 hours, and subsequent visits (including those by women who deliver in a health facility) should be made at three days, seven days, and six weeks after delivery. It is also recommended that women who deliver in a health facility should be kept for at least 48 hours (up to 72 hours depending on the capacity of the institution) so the mothers and infants may be monitored by skilled personnel.

To assess the extent of postnatal care utilization, respondents were asked, for the last birth in the two years preceding the survey, whether they had received a checkup after delivery, the timing of the first check-up, and the type of health provider performing the postnatal check-up. This information is presented according to background characteristics in Tables 7.10 and 7.11.



Overall, 38 percent of mothers received a postnatal checkup within the first 2 days for the most recent birth in the two years preceding the survey. About one-third of mothers received a postnatal checkup within 4 hours after delivery. A large majority of mothers (61 percent) said they did not have a postnatal care checkup. The proportion of women who receive a postnatal checkup within two days after delivering decreases as maternal age at birth increases. It also generally decreases as birth order increases. As expected, women who deliver in health facilities are far more likely to receive a postnatal checkup than women who do not (74 percent and 2 percent, respectively).

**Table 50\_7.10 Timing of first postnatal checkup**

Among women age 15-49 giving birth in the two years preceding the survey, the percent distribution of the mother's first postnatal check-up for the last live birth by time after delivery, and the percentage of women with a live birth in the two years preceding the survey who received a postnatal checkup in the first two days after giving birth, according to background characteristics, Afghanistan 2014

Background characteristic	Time after delivery of mother's first postnatal checkup							Total	Percentage of women with a postnatal checkup in the first two days after birth	Number of women
	Less than 4 hours	4-23 hours	1-2 days	3-6 days	7-41 days	Don't know/missing	No postnatal checkup <sup>1</sup>			
<b>Mother's age at birth</b>										
<20	51.6	0.0	1.8	0.0	0.6	0.0	45.9	100.0	53.4	60
20-34	27.7	3.6	4.6	0.0	0.7	0.8	62.6	100.0	35.9	277
35-49	19.6	3.2	3.4	2.2	0.0	2.9	68.7	100.0	26.2	40
<b>Birth order</b>										
1	43.9	2.0	5.3	0.0	0.0	0.0	48.7	100.0	51.3	72
2-3	36.6	2.3	8.1	0.0	1.4	2.1	49.4	100.0	47.0	103
4-5	21.4	5.9	0.1	0.0	0.2	0.0	72.4	100.0	27.4	95
6+	24.2	1.6	2.8	0.8	0.7	1.1	68.9	100.0	28.5	107
<b>Place of delivery</b>										
Health facility	61.3	4.8	7.6	0.0	0.7	1.8	23.7	100.0	73.8	186
Elsewhere	0.7	1.1	0.5	0.5	0.6	0.0	96.7	100.0	2.3	191
<b>Education</b>										
No education	30.5	3.2	4.8	0.2	0.8	1.1	59.5	100.0	38.5	318
Primary	(44.5)	(0.0)	(0.0)	(1.3)	(0.0)	(0.0)	(54.2)	100.0	(44.5)	20
Secondary	(21.6)	(2.5)	(0.0)	(0.0)	(0.0)	(0.0)	(75.9)	100.0	(24.1)	36
Higher	*	*	*	*	*	*	*	100.0	*	4
Total	30.7	3.0	4.0	0.2	0.6	0.9	60.6	100.0	37.6	377

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

<sup>1</sup> Includes women who received a checkup after 41 days

Table 7.11 shows the type of provider of the mother's first postnatal checkup that took place within two days after the last live birth: only 38 percent of women received a postnatal checkup from a skilled provider (doctor, nurse, midwife, or auxiliary midwife). Younger mothers and those who delivered in a health facility are more likely to have had a postnatal checkup from a doctor, nurse or midwife.

**Table 51\_7.11 Type of provider of first postnatal checkup for the mother**

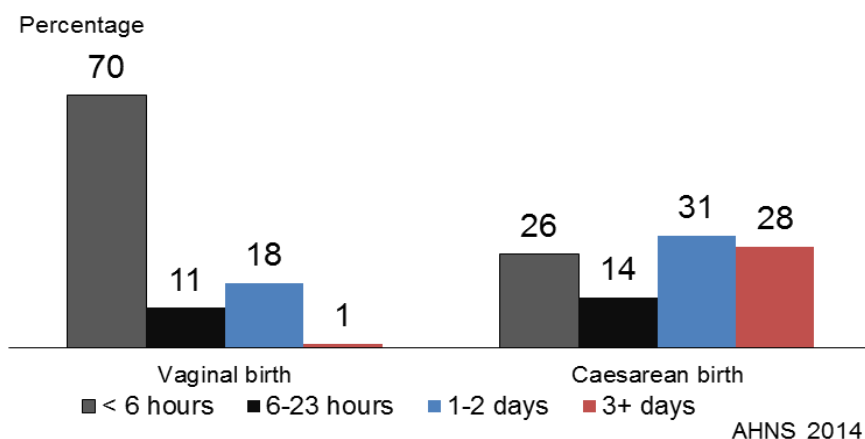
Among women age 15-49 giving birth in the two years preceding the survey, the percent distribution by type of provider of the mother's first postnatal health check in the two days after the last live birth, according to background characteristics, Afghanistan 2014

Background characteristic	Type of health provider of mother's first postnatal checkup					No postnatal checkup in the first two days after birth	Total	Number of women
	Doctor	Nurse/ midwife	Auxiliary midwife	Village health worker	Traditional birth attendant			
<b>Mother's age at birth</b>								
<20	29.3	24.2	0.0	0.0	0.0	46.6	100.0	60
20-34	26.4	5.9	3.5	0.0	0.0	64.1	100.0	277
35-49	16.5	9.7	0.0	0.0	0.0	73.8	100.0	40
<b>Birth order</b>								
1	24.2	23.6	3.4	0.0	0.0	48.7	100.0	72
2-3	34.5	6.8	5.7	0.0	0.0	53.0	100.0	103
4-5	25.1	0.9	1.4	0.0	0.0	72.6	100.0	95
6+	19.2	9.2	0.1	0.0	0.0	71.5	100.0	107
<b>Place of delivery</b>								
Health facility	50.3	18.2	5.2	0.0	0.0	26.2	100.0	186
Elsewhere	1.9	0.4	0.0	0.0	0.0	97.7	100.0	191
<b>Education</b>								
No education	28.1	9.2	1.2	0.0	0.0	61.5	100.0	318
Primary	(13.4)	(1.0)	(30.2)	(0.0)	(0.0)	(55.5)	100.0	20
Secondary	(9.4)	(14.7)	(0.0)	(0.0)	(0.0)	(75.9)	100.0	36
Higher	*	*	*	*	*	*	100.0	4
Total	25.8	9.2	2.6	0.0	0.0	62.4	100.0	377

<sup>1</sup> Includes women who received a checkup after 41 days

As mentioned above, it is recommended that women who deliver in health facilities stay at least two days. Women interviewed in the AHNS who delivered their most recent birth in a health facility, were asked how long they stayed in the facility after the delivery. As shown in Figure 7.1, the vast majority of women who had a vaginal delivery said they stayed less than 6 hours at the facility. As expected, those who delivered by Caesarean section were more likely to stay in the facility for three or more days than those with a vaginal delivery (28 percent and 1 percent, respectively).

**Figure 4\_7.1 Mother's duration of stay in the health facility after giving birth**



## 7.10 Postnatal Care For The Newborn

As mentioned, a significant proportion of neonatal deaths occur during the first few hours of life (48 hours) after delivery. The provision of postnatal care services for newborns should therefore start as soon as possible after the child is born. The timing of the postnatal checkup for the newborn is similar to that of the mother in that it should occur within two days after birth.

In view of the fact that almost half of births in the program area are assisted by skilled providers, it is surprising that only 8 percent of last births in the two years preceding the survey were reported to have received a postnatal checkup in the first two days of life (Table 7.12). No newborn was reported to have received a postnatal checkup less than 1 hour after birth, while 5 percent were checked within 1 to 3 hours. Ninety-two percent of newborns did not receive a postnatal checkup. Differences by background characteristics do not show strong patterns. Surprisingly, only 11 percent of babies born in a health facility received a postnatal checkup.

**Table 52\_7.12 Timing of first postnatal checkup for the newborn**

Percent distribution of last births in the two years preceding the survey by time after birth of first postnatal checkup, and the percentage of births with a postnatal checkup in the first two days after birth, according to background characteristics, Afghanistan 2014

Background characteristic	Time after birth of newborn's first postnatal checkup						No postnatal checkup <sup>1</sup>	Total	Percentage of births with a postnatal checkup in the first two days after birth	Number of births
	Less than 1 hour	1-3 hours	4-23 hours	1-2 days	3-6 days	Don't know/missing				
<b>Mother's age at birth</b>										
<20	0.0	9.1	1.2	0.0	0.0	0.6	89.0	100.0	10.4	60
20-34	0.0	4.3	0.9	0.8	0.3	0.0	93.7	100.0	6.0	277
35-49	0.0	4.2	9.0	0.2	0.0	0.0	86.7	100.0	13.3	40
<b>Birth order</b>										
1	0.0	7.2	1.2	0.4	1.2	0.5	89.5	100.0	8.7	72
2-3	0.0	7.3	0.7	1.3	0.0	0.0	90.7	100.0	9.3	103
4-5	0.0	1.1	3.1	0.6	0.0	0.0	95.3	100.0	4.7	95
6+	0.0	5.1	2.1	0.1	0.0	0.0	92.6	100.0	7.4	107
<b>Place of delivery</b>										
Health facility	0.0	9.6	0.6	0.4	0.0	0.0	89.4	100.0	10.6	186
Elsewhere	0.0	0.7	3.0	0.8	0.4	0.2	94.9	100.0	4.5	191
<b>Mother's education</b>										
No education	0.0	5.3	2.2	0.6	0.3	0.0	91.6	100.0	8.1	318
Primary	(0.0)	(2.1)	(0.0)	(0.0)	(0.0)	(2.0)	(95.9)	100.0	(2.1)	20
Secondary	(0.0)	(4.1)	(0.0)	(0.0)	(0.0)	(0.0)	(95.9)	100.0	(4.1)	36
More than secondary	*	*	*	*	*	*	*	100.0	*	4
Total	0.0	5.1	1.8	0.6	0.2	0.1	92.2	100.0	7.5	377

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

<sup>1</sup> Includes newborns who received a checkup after the first week

Survey results also show that 7 percent of newborns received postnatal care from a doctor in the first two days of life, while 1 percent received care from a nurse or midwife (table not shown). None was reported to have received postnatal care from any other type of provider.

**Key Findings**

- Two-thirds of children ages 12-23 months (67 percent) were fully vaccinated at the time of the survey.
- Among children under five, 11 percent were reported by the mother to have experienced symptoms of an acute respiratory infection (ARI) in the two weeks preceding the survey, while 18 percent had a fever and 19 percent had diarrhea in the two weeks preceding the survey.
- 85 percent of mothers with a birth in the past five years have heard of oral rehydration packets to treat diarrhea and 70 percent know that a child with diarrhea should be given more to drink than usual.

**T**his chapter presents findings about indicators related to child health, including characteristics of the neonate (birth weight and size), the vaccination status of young children, and treatment practices—particularly contact with health services—among children suffering from three childhood illnesses: acute respiratory infection (ARI), fever, and diarrhea. Because appropriate sanitary practices can help prevent and reduce the severity of diarrheal disease, information is also provided on how children’s fecal matter is disposed of.

## 8.1 High-Risk Fertility Behavior

Typically, infants and young children have a higher risk of dying if they are born to very young mothers or older mothers, if they are born after a short birth interval, or if their mothers have already had many children. In the following analysis, mothers are classified as at risk if they are younger than age 18 or older than age 35 at the time of childbirth. A short birth interval is defined as less than 24 months, and a high-order birth is defined as occurring after three or more previous births (i.e., birth order 4 or higher). A child may be at an elevated risk of dying due to a combination of factors.

The first column of Table 8.2 shows the percentage of births in the five years before the survey classified by various risk categories. Overall, 71 percent of births involved at least one avoidable risk factor, with 46 percent involving a single risk factor and 26 percent involving multiple risk factors. The most common single risk factor is high birth order, followed by short birth intervals. Including births in multiple high-risk categories, a total of 56 percent of births are fourth or higher order.

The second column in Table 8.1 presents risk ratios, which represent the increased risk of mortality among births in various high-risk categories relative to births not having any high-risk characteristics. Among births involving a single risk factor, a birth interval less than 24 months (risk ratio of 7.1) is the single factor most associated with increased risk of under-5 mortality, with 9 percent of births falling in this category. Overall, the risk ratio for births in the single high-risk categories was 2.9. Births falling into multiple high-risk factor categories were generally associated with higher risk ratios than those in the single high-risk categories, with an overall risk ratio of 4.1.

The third column of Table 8.1 shows the distribution of currently married women by the risk category into which a birth conceived at the time of the survey would fall. The data show that 13 percent of women are not in any high-risk category, and 7 percent are only at risk of having their first birth between ages 18 and 34, which is considered to be an unavoidable risk. Eighty percent of currently married women interviewed in the 2014 AHNS have at least one avoidable risk factor, with 34 percent having a single risk factor and 46 percent having multiple risk factors.

**Table 53\_8.1 High-risk fertility behavior**

Percent distribution of children born in the five years preceding the survey by category of elevated risk of mortality and the risk ratio, and percent distribution of currently married women by category of risk if they were to conceive a child at the time of the survey, Afghanistan 2014

Risk category	Births in the 5 years preceding the survey		Percentage of currently married women <sup>1</sup>
	Percentage of births	Risk ratio	
Not in any high risk category	15.9	1.00	13.2
<b>Unavoidable risk category</b>			
First order births between ages 18 and 34 years	12.9	4.13	7.2
<b>Single high-risk category</b>			
Mother's age <18	4.9	(5.80)	0.4
Mother's age >34	0.7	*	4.2
Birth interval <24 months	9.4	7.10	6.4
Birth order >3	30.7	1.20	22.7
Subtotal	45.7	2.90	33.7
<b>Multiple high-risk category</b>			
Age <18 and birth interval <24 months <sup>2</sup>	0.5	*	0.0
Age >34 and birth interval <24 months	0.0	*	0.0
Age >34 and birth order >3	11.2	0.35	32.5
Age >34, birth interval <24 months and birth order >3	2.0	*	3.4
Birth interval <24 months and birth order >3	11.8	6.15	10.0
Subtotal	25.5	4.13	45.9
In any avoidable high-risk category	71.3	3.34	79.6
Total	100.0	na	100.0
Number of births/women	1,024	na	943

Note: Risk ratio is the ratio of the proportion dead among births in a specific high-risk category to the proportion dead among births not in any high-risk category. A figure in parentheses is based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

na = Not applicable

<sup>1</sup> Women are assigned to risk categories according to the status they would have at the birth of a child if they were to conceive at the time of the survey: current age less than 17 years and 3 months or older than 34 years and 2 months, latest birth less than 15 months ago, or latest birth being of order 3 or higher.

<sup>2</sup> Includes the category age <18 and birth order >3

<sup>a</sup> Includes sterilized women

## 8.2 Child's Weight and Size at Birth

Birth weight is an important indicator when assessing a child's health in terms of early exposure to morbidity and mortality. Children who weigh less than 2.5 kilograms, or are reported to be "very small" or "smaller than average," are considered to have a higher-than-average risk of early childhood death. In the 2014 AHNS, for births in the five years preceding the survey, birth weight was recorded in the Woman's Questionnaire based on either a written record or the mother's report. The mother's estimate of the infant's size at birth was also obtained because birth weight may be unknown for many infants. Although the mother's estimate of size is subjective, it can be a useful proxy for the child's weight.

Table 8.2 shows that birth weight was reported for only 3 percent of the live births that occurred in the five years preceding the survey. This is too few cases to allow meaningful estimates of the proportion with low birth weights.

**Table 54\_8.2 Child's size at birth**

Percent distribution of live births in the five years preceding the survey by mother's estimate of baby's size at birth and percentage of live births in the five years preceding the survey that have a reported birth weight, according to background characteristics, Afghanistan 2014

Background characteristic	Percent distribution of all live births by size of child at birth				Total	Percentage of births that have a reported birth weight <sup>1</sup>	Number of births
	Very small	Smaller than average	Average or larger	Don't know/missing			
<b>Mother's age at birth</b>							
<20	2.9	13.2	82.5	1.4	100.0	1.3	152
20-34	5.9	16.8	76.7	0.6	100.0	3.4	730
35-49	9.6	19.9	70.5	0.0	100.0	2.8	142
<b>Birth order</b>							
1	5.0	16.0	77.7	1.3	100.0	4.1	169
2-3	5.7	16.6	77.3	0.4	100.0	3.5	282
4-5	5.7	15.0	78.4	0.9	100.0	1.2	257
6+	6.9	18.5	74.3	0.3	100.0	3.5	317
<b>Mother's education</b>							
No education	5.1	16.3	77.9	0.7	100.0	3.5	895
Primary	9.4	25.6	65.0	0.0	100.0	0.0	52
Secondary	14.5	14.4	70.3	0.8	100.0	0.0	69
More than secondary	*	*	*	0.0	*	*	9
Total	6.0	16.7	76.7	0.6	100.0	3.1	1,024

<sup>1</sup> Based on either a written record or the mother's recall

Table 8.2 also includes information on a mother's estimate of her infant's size at birth. Six percent of births are reported as very small, 17 percent as smaller than average, and 77 percent as average or larger than average. Births to older mothers age 35-49 are more likely to be reported as very small or smaller than average (30 percent) than those to mothers age less than 20 (16 percent). Births to mothers with only primary education are the most likely to be reported as very small or smaller than average (35 percent).

## 8.3 Vaccination of Children

To enable evaluation of the child vaccination program, the AHNS collected information on vaccine coverage for all children born since January 2009. To be fully vaccinated, a child should have received one dose of BCG vaccine, three doses each of pentavalent and polio vaccines, and one dose of measles vaccine. BCG protects against tuberculosis, and pentavalent protects against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, and haemophilus influenza type B or HiB.

In Afghanistan, the Ministry of Public Health has defined a schedule for the administration of all basic childhood vaccines. BCG should be given shortly after birth. Polio0 should be given at birth or within 14 days of birth. Three doses of pentavalent and polio vaccines should be given at approximately age 6, 10, and 14 weeks, and measles vaccine should be given at or soon after reaching age 9 months.

Information on vaccination coverage was obtained in the survey in two ways—from child health cards and from mothers’ verbal reports. All mothers were asked to show the interviewer the child health cards in which immunization dates were recorded for all children born since January 2009. If a card was available, the interviewer recorded onto the questionnaire the dates of each vaccination received by the child. If a card indicated that the child was not fully vaccinated, the mother was then asked whether the child had received other vaccinations that were not recorded on the card, and they too were noted on the questionnaire. If a child never received a health card or if the mother was unable to show the card to the interviewer, the vaccination information for the child was based on the mother’s report. Questions were asked for each vaccine type. Mothers were asked to recall whether the child had received BCG, polio, pentavalent, and measles vaccinations. If the mother indicated that the child had received the polio or penta vaccines, she was asked about the number of doses that the child received. The results presented here are based on both vaccination card information and, for children without a card, information provided by the mother.

Table 8.3 shows vaccination coverage by source of information for children age 12-23 months, the age by which they should have received all vaccinations. Mothers showed interviewer’s vaccination cards for 61 percent of children age 12-23 months, while for the remainder, the mother provided a self-report of children’s vaccination histories.

Overall, 67 percent of children ages 12-23 months were fully vaccinated at the time of the survey. Eighty-two percent had received the BCG vaccination at any time before the survey. For the pentavalent vaccine, 75 percent had received the first dose, 73 percent had received the second dose, and 69 percent had received the third dose. For polio vaccine, 86 percent had received the first dose (Polio1), 79 percent had received the second dose, and 73 percent had received the third dose. Coverage for measles was 76 percent. Eleven percent of children age 12-23 months had not received any vaccinations. Coverage levels for the various vaccines are surprisingly even with remarkably low drop-out rates. Rather, the problem seems to be the need to increase the coverage for initial vaccines like BCG, Penta 1 and Polio 1 at the same time as keeping the drop-out as low as it is.

Survey results are higher than the national average of 51 percent of children age 12-23 months fully vaccinated in 2013 (GDPM, 2014). However, the EPI survey also reports higher than average coverage for the four program provinces: Badakhshan (51 percent), Baghlan (63 percent), Bamyán (81 percent) and Takhar (70 percent).

**Table 55\_8.3 Vaccinations by source of information**

Percentage of children age 12-23 months who received specific vaccines at any time before the survey, by source of information (vaccination card or mother’s report), and percentage vaccinated 12 months of age, Afghanistan 2014

Source of information	BCG	Penta 1	Penta 2	Penta 3	Polio 0 <sup>1</sup>	Polio 1	Polio 2	Polio 3	Measles	All basic vaccinations <sup>2</sup>	No vaccinations	Number of children
<b>Vaccinated at any time before survey</b>												
Vaccination card	60.8	60.8	60.8	60.5	60.8	60.8	60.8	60.5	60.8	60.5	0.0	170
Mother’s report	21.3	14.4	12.3	8.7	15.8	24.6	18.3	12.5	14.7	6.1	11.1	109
Either source	82.2	75.3	73.2	69.2	76.6	85.5	79.2	73.1	75.6	66.7	11.1	279
Vaccinated by 12 months of age <sup>3</sup>	52.0	58.1	50.1	34.2	48.9	63.3	52.0	41.0	52.9	30.4	29.5	279

<sup>1</sup> Polio 0 is the polio vaccination given at birth.

<sup>2</sup> BCG, measles and three doses each of penta and polio vaccine (excluding polio vaccine given at birth)

<sup>3</sup> For children whose information is based on the mother’s report, the proportion of vaccinations given during the first year of

life is assumed to be the same as for children with a written record of vaccination.

Table 8.4 shows results on vaccination coverage by sex and birth order of the child. Data are presented for children age 12-23 months, thereby including only those children who have reached the age by which they should be fully vaccinated. The results refer to the proportions of children vaccinated at any time before the survey, not necessarily before age 12 months. Analysis of differences in vaccination coverage by background characteristics is hampered by the small number of children in the eligible age range. Nevertheless, there appears to be no large differences by sex of the child. First births seem to be more likely to receive all the basic vaccines than children of higher birth orders.

**Table 56\_8.4 Vaccinations by sex and birth order**

Percentage of children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), and percentage with a vaccination card, by sex and birth order, Afghanistan 2014

Sex/ Birth order	BCG	Penta 1	Penta 2	Penta 3	Polio 0 <sup>1</sup>	Polio 1	Polio 2	Polio 3	Measles	All basic vaccinations <sup>2</sup>	No vaccinations	Percentage with a vaccination card seen	Number of children
<b>Sex</b>													
Male	79.4	75.4	71.8	67.6	73.3	82.3	79.5	73.8	74.9	65.4	12.5	61.3	150
Female	85.4	75.1	74.7	71.1	80.5	89.2	78.8	72.2	76.3	68.2	9.6	60.3	129
<b>Birth order</b>													
1	93.9	82.2	80.5	78.6	91.8	91.8	79.4	77.2	81.1	77.2	6.1	73.3	65
2-3	78.7	71.7	69.5	61.1	70.9	79.9	76.7	65.7	70.5	57.8	14.0	55.7	77
4-5	83.1	76.0	74.4	70.7	85.4	87.6	82.1	74.3	80.3	67.2	8.2	61.5	63
6+	74.6	72.3	69.3	68.2	61.6	83.8	78.9	76.0	71.9	66.1	15.1	54.6	74
Total	82.2	75.3	73.2	69.2	76.6	85.5	79.2	73.1	75.6	66.7	11.1	60.8	279

<sup>1</sup> Polio 0 is the polio vaccination given at birth.  
<sup>2</sup> BCG, measles and three doses each of penta and polio vaccine (excluding polio vaccine given at birth)

## 8.5 Prevalence of Acute Respiratory Infection

Acute respiratory infection (ARI) is among the leading causes of childhood morbidity and mortality throughout the world. Among acute respiratory diseases, pneumonia is the most serious for young children. Early diagnosis and treatment with antibiotics can prevent a large number of deaths caused by ARIs.

In the 2014 AHNS, ARI prevalence was estimated by asking mothers whether, in the two weeks preceding the survey, any of their children under 5 had been ill with a cough accompanied by short, rapid breathing, which was chest-related, and/or by difficult breathing, which was chest-related. It should be noted that these data are subjective in the sense that they are based on the mother's perception of illness without validation by medical personnel.

Table 8.5 shows the prevalence of ARI symptoms among children under 5 during the two-week period preceding the interview. Overall, 11 percent of children are reported to have had ARI symptoms in the two weeks preceding the survey. Children age 12-23 months are the most likely to have had ARI. Boys are slightly more likely than girls to have had ARI in the two weeks before the survey. Children whose mothers have been to secondary school are the least likely to have had ARI.

Overall, 59 percent of children with ARI symptoms were taken to a health facility or medical provider for advice or treatment. Sixty percent of the children were given antibiotics.



**Table 57\_8.5 Prevalence and treatment of symptoms of ARI**

Among children under age five, the percentage who had symptoms of acute respiratory infection (ARI) in the two weeks preceding the survey and among children with symptoms of ARI, the percentage for whom advice or treatment was sought from a health facility or provider and the percentage who received antibiotics as treatment, according to background characteristics, Afghanistan 2014

Background characteristic	Among children under age five:		Among children under age five with symptoms of ARI:		
	Percentage with symptoms of ARI <sup>1</sup>	Number of children	Percentage for whom advice or treatment was sought from a health facility or provider <sup>2</sup>	Percentage who received antibiotics	Number of children
<b>Age in months</b>					
<6	4.8	38	*	*	2
6-11	2.1	60	*	*	1
12-23	17.8	279	(55.6)	(55.9)	50
24-35	10.6	220	*	*	23
36-47	9.6	190	*	*	18
48-59	9.0	200	*	*	18
<b>Sex</b>					
Male	13.0	499	63.1	62.9	65
Female	9.8	488	(54.0)	(57.1)	48
<b>Mother's education</b>					
No education	11.3	861	57.8	60.0	98
Primary	18.3	51	*	*	9
Secondary	7.1	66	*	*	5
More than secondary	*	9	*	*	1
Total	11.4	987	59.3	60.4	113

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

<sup>1</sup> Symptoms of ARI (cough accompanied by short, rapid breathing which was chest-related and/or by difficult breathing which was chest-related) is considered a proxy for pneumonia

<sup>2</sup> Excludes pharmacy, shop, and traditional practitioner

<sup>3</sup> Includes grass, shrubs, crop residues

## 8.6 Prevalence of Fever

Fever is a symptom of malaria, but it may also accompany other illnesses including pneumonia, common colds, and influenza. In the 2014 AHNS, fever prevalence was estimated by asking mothers whether their children under 5 had been ill with fever in the two weeks preceding the survey.

Table 8.6 shows that 18 percent of children under 5 had a fever during the two weeks preceding the survey. The prevalence of fever varies with children's ages. Children ages 12-23 months are more likely to be sick with fever than children in other age groups. Male children seem to be more likely to have fever than female children.

Over half of children (56 percent) who had fever in the two weeks before the survey were taken to a health facility or provider for treatment. About one-quarter of children were given anti-malarial medicine, while one-half were given antibiotics.

**Table 58\_8.6 Prevalence and treatment of fever**

Among children under age five, the percentage who had a fever in the two weeks preceding the survey and among children with fever, the percentage for whom advice or treatment was sought from a health facility or provider, percentage who took antimalarial drugs, and the percentage who received antibiotics as treatment, by background characteristics, Afghanistan 2014

Background characteristic	Among children under age five:		Among children under age five with fever			
	Percentage with fever	Number of children	Percentage for whom advice or treatment was sought from a health facility or provider <sup>1</sup>	Percentage who took antimalarial drugs	Percentage who took antibiotic drugs	Number of children
<b>Age in months</b>						
<6	16.2	38	*	*	*	6
6-11	5.3	60	*	*	*	3
12-23	27.6	279	56.2	20.7	49.9	77
24-35	17.9	220	(61.1)	(29.6)	(53.6)	39
36-47	14.5	190	(48.7)	(30.4)	(42.2)	28
48-59	14.5	200	(65.6)	(28.0)	(52.9)	29
<b>Sex</b>						
Male	21.3	499	58.7	29.2	49.0	106
Female	15.5	489	53.2	17.2	47.8	76
<b>Mother's education</b>						
No education	18.7	861	56.1	26.5	48.2	161
Primary	22.5	51	*	*	*	12
Secondary	13.4	66	*	*	*	9
More than secondary	*	9	*	*	*	1
Total	18.4	987	56.4	24.2	48.5	182

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

<sup>1</sup> Excludes pharmacy, shop, market, and traditional practitioner

## 8.7 Diarrheal Disease

Dehydration caused by severe diarrhea is a major cause of morbidity and mortality among young children. Exposure to diarrhea-causing agents frequently relates to the use of contaminated water and to unhygienic practices in food preparation and disposal of excreta. The 2014 AHNS obtained information on the prevalence of diarrhea among young children by asking mothers whether their children under 5 had had diarrhea during the two weeks preceding the survey.

Table 8.7 shows that 19 percent of children under 5 had a diarrheal episode in the two weeks preceding the survey. The prevalence of diarrhea jumps from 13 percent among children less than age 6 months to 28 percent among children age 12-23 months, before declining gradually with age. This observation is expected because children around age 12 months are typically introduced to liquids in addition to breast milk and complementary foods. Diarrhea appears to be slightly more prevalent among male children than among female children. As might be expected, the prevalence of diarrhea among young children is higher for those who live in households with non-improved sources of drinking water and non-improved types of toilets.

**Table 59\_8.7 Prevalence of diarrhea**

Percentage of children under age five who had diarrhea in the two weeks preceding the survey, by background characteristics, Afghanistan 2014

Background characteristic	Percentage with diarrhea	Number of children
<b>Age in months</b>		
<6	12.8	38
6-11	14.9	60
12-23	27.8	279
24-35	22.5	220
36-47	13.7	190
48-59	11.6	200
<b>Sex</b>		
Male	23.4	499
Female	15.0	488
<b>Source of drinking water<sup>1</sup></b>		
Improved	17.0	543
Not improved	22.0	444
<b>Toilet facility<sup>2</sup></b>		
Improved, not shared	15.9	296
Shared <sup>3</sup>	14.5	118
Non-improved	21.9	573
<b>Mother's education</b>		
No education	20.0	861
Primary	12.6	51
Secondary	15.3	66
More than secondary	*	9
Total	19.3	987

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

<sup>1</sup> See Table 2.1 for definition of categories

<sup>2</sup> See Table 2.2 for definition of categories

<sup>3</sup> Facilities that would be considered improved if they were not shared by two or more households

A simple and effective response to dehydration caused by diarrhea is oral rehydration therapy (ORT). Oral rehydration salt (ORS) packets are one source of rehydration therapy available in Afghanistan.

Table 8.9 shows that advice or treatment was sought from a health facility or provider for over half of children suffering from diarrhea. Some form of ORT, either fluid from ORS packets or recommended home fluids (RHF), was used to treat the diarrhea in the majority of children (74 percent); 23 percent of children suffering from diarrhea in the two weeks preceding the survey were given RHF, and 67 percent were given fluid from ORS packets. Forty-two percent of the children were given increased amounts of other fluids. Four out of five children (82 percent) were given either ORT or increased fluids.

Other treatments given to children with diarrhea were principally antibiotics (6 percent) and anti-motility drugs (20 percent), and zinc supplements (5 percent). Home remedies were used to treat 24 percent of children. Eleven percent of children with diarrhea did not receive any treatment.

There were too few children with diarrhea in the two weeks before the survey to provide much meaningful breakdown of treatment practices by background characteristics. However, it does appear that male children are slightly more likely to be taken for treatment when they have diarrhea than are female children.

**Table 60\_8.9 Diarrhea treatment**

Among children under age five who had diarrhea in the two weeks preceding the survey, the percentage for whom advice or treatment was sought from a health facility or provider, the percentage given oral rehydration therapy (ORT), the percentage given increased fluids, the percentage given ORT or increased fluids, and the percentage who were given other treatments, by background characteristics, Afghanistan 2014

Background characteristic	Percentage of children with diarrhea for whom advice or treatment was sought from a health facility or provider <sup>1</sup>	Oral rehydration therapy (ORT)					Other treatments						Number of children with diarrhea	
		Fluid from ORS packets or pre-packaged liquid	Recommended home fluids (RHF)	Either ORS or RHF	In-creased fluids	ORT or in-creased fluids	Anti-biotic drugs	Anti-motility drugs	Zinc supplements	Intra-venous solution	Home remedy/ other	No treatment		
<b>Age in months</b>														
<6	*	*	*	*	*	*	*	*	*	*	*	*	*	5
6-11	*	*	*	*	*	*	*	*	*	*	*	*	*	9
12-23	60.5	68.4	10.5	70.8	47.4	82.3	10.9	30.4	9.8	1.3	29.5	6.4	78	
24-35	(54.3)	(68.4)	(45.3)	85.3	(38.4)	(91.1)	3.1	(5.9)	(0.0)	(0.0)	(25.2)	(4.9)	49	
36-47	(36.0)	(54.1)	(1.7)	54.1	(46.6)	(68.3)	2.0	(6.8)	(8.4)	(10.9)	(22.6)	(31.7)	26	
48-59	*	*	*	*	*	*	*	*	*	*	*	*	*	23
<b>Sex</b>														
Male	54.1	71.6	20.2	78.0	39.7	82.3	6.3	23.6	2.4	0.8	22.9	10.3	117	
Female	50.0	60.4	27.2	67.3	45.4	82.3	4.7	15.4	10.0	3.9	26.1	13.2	73	
Total	52.5	67.3	22.9	73.9	41.9	82.3	5.7	20.4	5.4	2.0	24.1	11.4	190	

When a child has diarrhea, mothers are encouraged to continue feeding their child the same amount of food as they would if the child did not have diarrhea, and they are also encouraged to increase the child's fluid intake. These practices help to reduce dehydration and minimize the adverse consequences of diarrhea on the child's nutritional status. In the 2014 AHNS, mothers were asked whether they gave their child with diarrhea less, the same amount of, or more fluids and food than usual.

Table 8.10 shows, by feeding practices, the percent distribution of children under 5 who had diarrhea in the two weeks preceding the survey, according to background characteristics. Forty-two percent of the children with diarrhea were given more liquids than usual and 28 percent were given the same amount. It is of concern that 14 percent of the children were given somewhat less and 15 percent were given much less to drink during the diarrhea episode.

Twelve percent of children with diarrhea were given the more food than usual, 35 percent were given the same amount as usual, 41 percent were given somewhat less food, and 8 percent were given much less food. Three percent of children were not given any food during the diarrhea episode. Overall, only 34 percent of children had increased fluid intake and continued feeding. However, 71 percent of children were given ORT and/or increased fluids, and continued feeding.

**Table 61\_8.10 Feeding practices during diarrhea**

Percent distribution of children under age five who had diarrhea in the two weeks preceding the survey by amount of liquids and food offered compared with normal practice, the percentage of children given increased fluids and continued feeding during the diarrhea episode, and the percentage of children who continued feeding and were given ORT and/or increased fluids during the episode of diarrhea, by background characteristics, Afghanistan 2014

Back-ground characteristic	Amount of liquids given						Amount of food given							Percentage who continued feeding and were given increased fluids and continued feeding <sup>1</sup>	Percentage given ORT and/or increased fluids <sup>1</sup>	Number of children with diarrhea		
	More	Same as usual	Some - what less	Much less	None	Total	More	Same as usual	Some - what less	Much less	None	Never gave food	Don't know/miss-ing				Total	
<b>Age in months</b>																		
<6	*	*	*	*	*	100.0	*	*	*	*	*	*	*	*	100.0	*	*	5
6-11	*	*	*	*	*	100.0	*	*	*	*	*	*	*	*	100.0	*	*	9
12-23	47.4	27.3	16.0	9.3	0.0	100.0	20.6	27.1	46.7	5.6	0.0	0.0	0.0	100.0	42.5	76.7	78	
24-35	(38.4)	(27.2)	(6.0)	(24.7)	(3.7)	100.0	(9.1)	(46.4)	(31.9)	(12.6)	(0.0)	(0.0)	(0.0)	100.0	(36.9)	(80.3)	49	
36-47	(46.6)	(38.2)	(15.2)	(0.0)	(0.0)	100.0	(6.6)	(29.7)	(52.5)	(11.3)	(0.0)	(0.0)	(0.0)	100.0	(35.3)	(57.1)	26	
48-59	*	*	*	*	*	100.0	*	*	*	*	*	*	*	100.0	*	*	23	
<b>Sex</b>																		
Male	39.7	27.8	13.0	18.0	1.6	100.0	12.5	35.1	37.1	8.2	5.0	0.8	1.4	100.0	28.8	67.7	117	
Female	45.4	28.5	15.6	10.5	0.0	100.0	11.2	34.0	46.1	7.6	0.0	0.8	0.2	100.0	43.2	75.6	73	
Total	41.9	28.1	14.0	15.1	1.0	100.0	12.0	34.7	40.6	8.0	3.1	0.8	1.0	100.0	34.4	70.8	190	

Note: It is recommended that children should be given more liquids to drink during diarrhea and food should not be reduced. Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

<sup>1</sup> Continued feeding includes children who were given more, same as usual, or somewhat less food during the diarrhea episode

## 8.8 Knowledge of ORS Packets

To ascertain respondents' knowledge of oral rehydration solution (ORS), women who had a birth in the five years before the survey were asked whether they had heard of a special product called Rehedrone (the local name for oral rehydration salts—ORS—packets) that can be used to treat diarrhea. Table 8.11 shows that 85 percent of mothers had heard of the product. Younger mothers and those with some education are more likely to have heard of Rehedrone than older mothers and those with no education.

**Table 62\_8.11 Knowledge of Rehedrone packets**

Percentage of women age 15-49 with a live birth in the five years preceding the survey who know about Rehedrone for treatment of diarrhea by background characteristics, Afghanistan 2014

Background characteristic	Percentage of women who know about Rehedrone	Number of women
<b>Age</b>		
15-19	(92.8)	23
20-24	90.8	162
25-34	85.1	288
35-49	78.4	200
<b>Education</b>		
No education	82.7	586
Primary	98.3	35
Secondary	98.4	47
Higher	*	4
Total	84.7	673

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

## 8.9 Knowledge of Amount of Fluids to Give During Diarrhea

When a child has diarrhea, mothers/caretakers are encouraged to continue feeding their child the same amount of food as they would if the child did not have diarrhea, and they are also encouraged to increase the child's fluid intake. These practices help to reduce dehydration and minimize the adverse consequences of diarrhea on the child's nutritional status. In the 2014 AHNS, mothers were asked how much a child with diarrhea should be given to drink: more than usual, about the same as usual, less than usual or nothing to drink at all.

As shown in Table 8.12, 70 percent of women who had a birth in the five years before the survey are aware that children with diarrhea should be given more fluids than usual. Only 5 percent of women said a child should be given less to drink than usual.

**Table 63\_8.12 Knowledge of amount of fluids to give during diarrhea**

Among all women age 15-49 with a birth in the five years before the survey, percent distribution by amount of fluids to give a child with diarrhea, Afghanistan 2014

Amount of fluid	Percentage
More than usual	69.5
About the same	18.4
Less than usual	4.6
Don't know	7.4
Total	100.0
Number of women	673

## 8.10 Knowledge of Danger Signs of Severe Child Illness

An obvious way to reduce child morbidity and death is to ensure that children in danger obtain medical care promptly. An important aspect of improving prompt medical care is awareness of symptoms of serious illness.

In order to assess this awareness, in the 2014 AHNS, mothers of children under five were asked the following: "Sometimes children have severe illnesses and should be taken immediately to a health facility. What types of symptoms would cause you to take your child to a health facility or medical worker right away?" Results are shown in Table 8.13 separately for all ever-married women and for women who had a birth in the five years before the survey.

The symptom most commonly mentioned as a sign of serious illness is that the child is unable to drink or breastfeed; 57 percent of women said this would indicate that a child needed to be taken for medical care immediately. Vomiting was mentioned by almost half of women. About one-third of women mentioned high fever, yellow skin, fast breathing, difficult breathing, and lethargy/unconsciousness as signs of serious illness in a child. Other symptoms were mentioned less frequently.

**Table 64\_8.13 Knowledge of danger signs of severe child illnesses**

Among all women age 15-49 and women age 15-49 with a birth in the five years before the survey, percentage who mention specific symptoms that would cause them to take their child to a health facility or medical worker right away, Afghanistan 2014

Symptom	Percentage of all ever-married women	Percentage of women with a birth in the five years before the survey
Child not able to drink or breastfeed	56.6	56.9
Vomits any food or drink	48.5	48.0
Convulsions	10.5	11.5
Lethargic/Unconscious	30.3	31.1
Child becomes sicker	29.9	28.1
Child has high fever	34.9	35.2
Child has fast breathing	31.0	33.4
Child has difficult breathing	30.5	31.2
Child does not cry	19.0	19.8
Child's skin is yellow	31.5	32.5
Child is very cold or shivering	20.6	22.0
Child has blood in stool	13.0	10.4
Other	0.2	0.3
Number of women	974	673

**Key Findings**

- 60 percent of children under five are stunted or short for their age; 6 percent are wasted or thin for their height.
- All children are breastfed at some point in their life; however, only 62 percent of children under 6 months are exclusively breastfed.
- The median duration for breastfeeding is 24 months. However, exclusive breastfeeding is short, with a median duration of less than 5 months.
- The feeding practices of only 15 percent of children age 6-23 months meet the minimum standards for infant and young child feeding (IYCF) practices.
- 39 percent of children age 6-59 months received a vitamin A supplement in the six months before the survey and 28 percent received iron supplements in the 7 days before the survey; 26 percent received deworming medication in the preceding 6 months.
- Among women with a child born in the past five years, 45 percent took iron tablets during pregnancy, but only 3 percent took them for the recommended period of time.

**T**his chapter focuses on infant and young child feeding practices, including breastfeeding and weaning; diversity of foods fed; frequency of feeding; and micronutrient status and supplementation. The discussion also covers micronutrient supplements during pregnancy.

**9.1 Nutritional Status of Children**

The 2014 AHNS collected data on the nutritional status of children by measuring the height and weight of children under five. Data came from the sample of households, regardless of whether the children's mothers were interviewed in the survey. Weight measurements were obtained using a SECA scale with a digital screen, designed and manufactured under the authority of the United Nations Children's Fund (UNICEF) for weighing children and adults. Height measurements were carried out using a measuring board made by Shorr Productions Inc. Children younger than 24 months were measured lying down on the board (recumbent length), and standing height was measured for older children.

Out of 994 children eligible for the anthropometric measurements, complete and credible anthropometric data and age data were available for 83 percent of the total eligible children (unweighted). Data are missing for 7 percent of children due to the child not being at home, refusal, or some other reason. Data for 11 percent of the children are characterized as flagged, because the information on the height, weight and/or age appears to be implausible.

It should be noted that collection of accurate data on ages of children was problematic in this survey. One factor is that Afghanistan uses a Persian solar calendar (Hijri Shamsi). Dates entered into the questionnaires were converted to the Gregorian calendar manually in the office and were checked by supervisors. Another issue is that eligibility for the height and weight measurement was based on the age of the child as reported by the respondent to the household questionnaire, which was often the male head of the household. Comparison of the age of children in the household and the birth history section of the woman's questionnaire indicated considerable discrepancies. An attempt was made by the ICF data



processing specialist to use the most appropriate date for the anthropometric analysis. Nevertheless, poor quality of age information could account for some of the high level of stunting found in the survey.

The nutritional status of children was calculated using growth standards published by WHO in 2006. These standards were generated through data collected in the WHO Multicentre Growth Reference Study (WHO, 2006). That study, which involved a sample of 8,440 children drawn from six countries across the world, was designed to describe how children should grow under optimal conditions. The WHO child growth standards can therefore be used to assess children all over the world, regardless of ethnicity, social and economic influences, and feeding practices. Each of the three nutritional status indicators described below is expressed in standard deviation units from the median of the Multicentre Growth Reference Study sample.

Three anthropometric indices of nutritional status (height-for-age, weight-for-height and weight-for-age) were used to determine whether children below five years of age are malnourished or not. Each of these indices—height-for-age, weight-for-height, and weight-for-age—provides different information about growth and body composition that can be used to assess nutritional status.

The height-for-age index is an indicator of linear growth retardation and cumulative growth deficits. Children whose height-for-age Z-score is below minus two standard deviations (-2 SD) from the median of the reference population are considered short for their age (stunted), or chronically malnourished. Children who are below minus three standard deviations (-3 SD) are considered severely stunted. Stunting reflects failure to receive adequate nutrition over a long period and is also affected by recurrent and chronic illness. Height-for age, therefore, represents the long-term effects of under nutrition in a population and is not sensitive to recent, short-term changes in dietary intake.

The weight-for-height index measures body mass in relation to body height or length and describes current nutritional status. Children whose Z-scores are below -2 SD from the median of the reference population are considered thin (wasted), or acutely malnourished. Wasting represents the failure to receive adequate nutrition in the period immediately preceding the survey. It may result from inadequate food intake or a recent episode of illness causing loss of weight and the onset of malnutrition. Children whose weight-for-height is below -3 SD are considered severely wasted.

Overweight and obesity are other forms of malnutrition that are becoming concerns for some children in developing countries. Children whose Z-score values are +2 SD above the median for weight-for-height are considered overweight.

Weight-for-age is a composite index of height-for-age and weight-for-height. It takes into account both acute and chronic malnutrition. Children whose weight-for-age is below -2 SD from the median of the reference population are classified as underweight. Children whose weight-for-age is below -3 SD from the median are considered severely underweight.

Z-score means are also calculated as summary statistics representing the nutritional status of children in a population. These mean scores describe the nutritional status of the entire population without the use of a cutoff. A mean Z-score of less than 0 (i.e., a negative value for stunting, wasting, or underweight) suggests that the distribution of an index has shifted downward and, on average, children in the population are less well-nourished than children in the WHO Multicentre Growth Reference Study.

Table 9.1 and Figure 9.1 present the results of the anthropometric measurements. They show that 60 percent of children under five are stunted and 38 percent are severely stunted, considerably higher than the national average of 41 percent found in 2013 (MOPH and UNICEF, 2014). The percentage stunted fluctuates by age group, being highest among children age 18-35 months (72 percent). Stunting decreases as the interval between births increases. Surprisingly, stunting increases slightly as education of the mother increases.

The total percentage of children characterized as wasted constitutes 6 percent. Three percent are severely wasted and 6 percent are overweight (above +2SD). The percentage of children who are wasted varies by age group. The lowest proportion (1 percent) is shown for children age 48-59 months and the highest (16 percent) occurs among children age 12-17 months. The proportion of children who are wasted decreases slightly as birth interval increases. Children who were very small at the time of birth are more likely to be wasted (16 percent) than those who were small or average sized at birth (5-6 percent).

Twenty-five percent of children were recorded as underweight (weight-for-age). Analysis by age group reveals that the highest percentage underweight (41 percent) is shown for children between 18-23 months of age. Children whose birth interval is less than 24 months are more likely to be underweight (37 percent) than those born four years or more after a prior sibling (20 percent). Similar to weight-for-height, the percentage of underweight children is much higher for children whose mothers said they were very small at birth than for those who were reported to be small or average at birth.

**Table 65\_9.1 Nutritional status of children**

Percentage of children under five years classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, by background characteristics, Afghanistan 2014

Background characteristic	Height-for-age <sup>1</sup>			Weight-for-height			Weight-for-age			Mean Z-score (SD)	Number of children	
	Per-centage below -3 SD	Per-centage below -2 SD <sup>2</sup>	Mean Z-score (SD)	Per-centage below -3 SD	Per-centage below -2 SD <sup>2</sup>	Per-centage above +2 SD	Per-centage below -3 SD	Per-centage below -2 SD <sup>2</sup>	Per-centage above +2 SD			
<b>Age in months</b>												
<6	(19.9)	(31.8)	0.8	(5.5)	(13.3)	(22.7)	-0.4	(4.1)	(10.3)	(7.2)	0.5	27
6-8	(3.6)	(6.5)	0.1	(7.4)	(8.6)	(1.7)	0.0	(4.9)	(6.5)	(0.0)	0.2	37
9-11	*	*	*	*	*	*	*	*	*	*	*	12
12-17	26.4	54.9	-2.0	4.4	15.5	3.7	-0.4	13.2	23.0	0.0	-1.3	126
18-23	57.4	72.1	-3.1	3.7	6.0	3.9	-0.1	24.5	40.9	0.5	-1.7	99
24-35	51.5	71.9	-2.9	2.8	7.6	7.8	0.2	14.9	37.3	1.5	-1.5	192
36-47	32.8	64.6	-2.4	1.3	2.9	5.3	0.4	4.2	20.9	0.0	-1.1	179
48-59	35.8	58.8	-2.4	0.7	0.7	5.0	0.5	4.4	17.1	0.1	-1.1	183
<b>Sex</b>												
Male	34.8	58.2	-2.3	2.9	7.2	4.4	0.1	10.5	25.1	0.7	-1.2	430
Female	40.5	62.6	-2.5	2.3	5.3	7.1	0.2	10.2	25.6	0.6	-1.3	424
<b>Birth interval in months<sup>3</sup></b>												
First birth <sup>4</sup>	38.5	62.3	-2.5	4.3	7.3	1.5	0.1	10.4	22.8	0.3	-1.3	135
<24	43.8	65.1	-2.6	3.9	9.8	2.0	-0.2	19.0	37.0	0.0	-1.6	180
24-47	35.5	59.8	-2.3	1.7	5.1	6.5	0.2	6.7	23.7	0.2	-1.2	382
48+	36.1	56.8	-2.1	2.1	4.1	10.8	0.3	9.6	19.5	3.1	-1.0	142
<b>Size at birth<sup>3</sup></b>												
Very small	42.1	58.8	-2.7	6.5	16.1	6.0	-0.6	34.4	47.4	0.4	-2.0	47
Small	40.6	60.5	-2.3	1.9	4.5	10.8	0.2	9.7	26.0	0.3	-1.2	140
Average or larger	37.0	61.0	-2.3	2.6	6.0	4.3	0.2	8.9	24.0	0.7	-1.2	649
<b>Mother's education<sup>5</sup></b>												
No education	38.0	60.3	-2.4	2.5	6.3	6.4	0.2	10.0	25.6	0.7	-1.2	743
Primary	34.4	65.2	-2.3	6.3	6.5	1.4	-0.1	5.6	19.2	0.0	-1.4	37
Secondary	44.7	69.9	-2.8	1.4	5.0	1.0	0.1	21.5	31.9	0.0	-1.6	58
More than secondary	*	*	*	*	*	*	*	*	*	*	*	8
Total	37.6	60.4	-2.4	2.6	6.2	5.7	0.2	10.4	25.4	0.6	-1.2	854

Note: Table is based on children who stayed in the household on the night before the interview. Each of the indices is expressed in standard deviation units (SD) from the median of the WHO Child Growth Standards adopted in 2006. The indices in this table are NOT comparable to those based on the previously used NCHS/CDC/WHO reference. Table is based on children with valid dates of birth (month and year) and valid measurement of both height and weight. Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed. Total includes 3 children missing information about size at birth.

<sup>1</sup> Recumbent length is measured for children under age 2, or in the few cases when the age of the child is unknown and the child is less than 85 cm; standing height is measured for all other children.

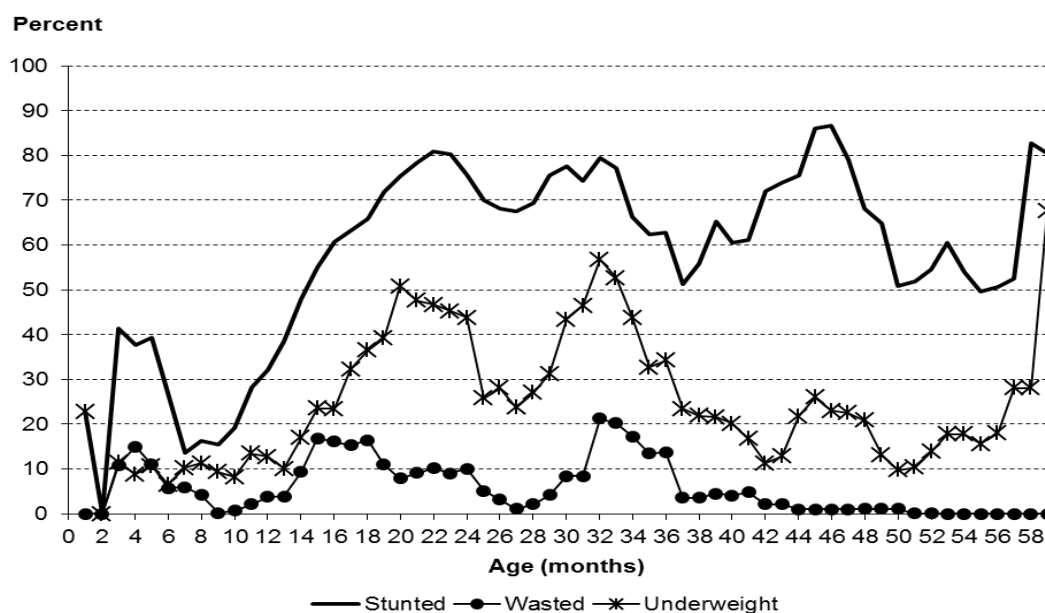
<sup>2</sup> Includes children who are below -3 standard deviations (SD) from the WHO Child Growth standards population median

<sup>3</sup> Excludes children whose mothers were not interviewed

<sup>4</sup> First-born twins (triplets, etc.) are counted as first births because they do not have a previous birth interval

<sup>5</sup> For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire

**Figure 5\_9.1: Nutritional status of children by age**



Note: *Stunting* reflects chronic malnutrition; *wasting* reflects acute malnutrition; *underweight* reflects chronic or acute malnutrition or a combination of both. Plotted values are smoothed by a five-month moving average.

AHNS 2014

## 9.2 Breastfeeding

AHNS data can be used to evaluate infant feeding practices, including breastfeeding duration, introduction of complementary weaning foods, and use of feeding bottles. The pattern of infant feeding has important influences on both the child and the mother. Feeding practices are the principal determinants of a child’s nutritional status. Biologically, breastfeeding suppresses the mother’s return to fertile status and affects the length of the birth interval. These effects are influenced by both the duration and frequency of breastfeeding and the age at which the child receives foods and liquids to complement breast milk.

### 9.2.1 Initiation of Breastfeeding

Early breastfeeding practices determine the successful establishment and duration of breastfeeding. Moreover, during the first three days after delivery, colostrum, an important source of nutrition and protection for the newborn, is produced and should be given to the newborn while awaiting the letdown of regular breast milk. Thus, it is recommended that children be put to the breast within one hour after birth and that prelacteal feeding (i.e., feeding anything other than breast milk before breast milk is regularly given) be discouraged.

Table 9.2 shows that 100 percent of last-born children born in the two years preceding the survey were breastfed at some point in their life, with no differences by background characteristics. Forty-four percent of newborns were breastfed within one hour of birth and 93 percent began breastfeeding within one day of birth.

The practice of giving prelacteal feeds limits the frequency of suckling by the infant and exposes the baby to the risk of infection. One in ten newborns received prelacteal feeds, with the practice being slightly more common among children who were delivered with the assistance of a health professional than among those who were born with non-professional assistance.

**Table 66\_9.2 Initial breastfeeding**

Among last-born children who were born in the two years preceding the survey, the percentage who were ever breastfed and the percentages who started breastfeeding within one hour and within one day of birth; and among last-born children born in the two years preceding the survey who were ever breastfed, the percentage who received a prelacteal feed, by background characteristics, Afghanistan 2014

Background characteristic	Among last-born children born in the past two years:			Among last-born children born in the past two years who were ever breastfed:		
	Percentage ever breastfed	Percentage who started breastfeeding within 1 hour of birth	Percentage who started breastfeeding within 1 day of birth <sup>1</sup>	Number of last-born children	Percentage who received a prelacteal feed <sup>2</sup>	Number of last-born children ever breastfed
<b>Sex</b>						
Male	100.0	41.7	91.2	206	9.1	206
Female	99.9	45.6	95.3	172	10.2	171
<b>Assistance at delivery</b>						
Health professional <sup>3</sup>	99.9	50.1	92.7	192	14.9	192
Traditional birth attendant	100.0	36.4	95.1	75	3.3	75
Other	100.0	36.6	92.7	109	4.8	109
No one	*	*	*	1	*	1
<b>Place of delivery</b>						
Health facility	99.9	50.9	93.9	186	15.3	186
At home	100.0	36.3	92.4	191	4.0	191
<b>Mother's education</b>						
No education	100.0	44.1	92.1	318	9.3	317
Primary	(100.0)	(44.2)	(96.2)	20	(3.8)	20
Secondary	(100.0)	(35.8)	(100.0)	36	(17.0)	36
More than secondary	*	*	*	4	*	4
Total	100.0	43.5	93.1	377	9.6	377

Note: Table is based on last-born children born in the two years preceding the survey regardless of whether the children are living or dead at the time of interview. Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

<sup>1</sup> Includes children who started breastfeeding within one hour of birth

<sup>2</sup> Children given something other than breast milk during the first three days of life

<sup>3</sup> Doctor, nurse/midwife, or auxiliary midwife

## 9.2.2 Breastfeeding Status by Age

Breast milk contains all of the nutrients needed by children in the first six months of life and is an uncontaminated nutritional source. Therefore, complementing breast milk before age 6 months is discouraged as the likelihood of contamination and resulting risk of diarrheal disease are high. Early initiation of complementary feeding also reduces breast milk output because the production and release of breast milk is modulated by the frequency and intensity of suckling.

Table 9.3 shows breastfeeding practices by child's age. Although 96 percent of infants under 6 months are being breastfed, only 62 percent are exclusively breastfed, only slightly higher than the national average of 58 percent (MOPH and UNICEF, 2014). Contrary to the recommendation that children under 6 months be exclusively breastfed, 10 percent of infants consume plain water, 6 percent consume non-milk liquids, 12 percent consume other milk, and 6 percent consume complementary foods in addition to breast milk. Nevertheless, breastfeeding is relatively long in duration; among children age 12-23 months, 86 percent are still being breastfed.

Feeding children using a bottle with a nipple is discouraged. While only 11 percent of children below age 6 months are fed using a bottle with a nipple, the prevalence of bottle-feeding climbs among

older children; more than one-quarter of children age 12-15 months are bottle-fed. Figure 9.2 depicts the transition of feeding practices among children up to age two years. Figure 9.3 presents infant and young child feeding (IYCF) indicators on breastfeeding.

**Table 67\_9.3 Breastfeeding status by age**

Percent distribution of youngest children under two years who are living with their mother by breastfeeding status and the percentage currently breastfeeding; and the percentage of all children under two years using a bottle with a nipple, according to age in months, Afghanistan 2014

Age in months	Breastfeeding status						Total	Percentage currently breastfeeding	Number of youngest children under two years living with their mother	Percentage using a bottle with a nipple	Number of all children under two years
	Not breastfeeding	Exclusively breastfed	Breast-feeding and consuming plain water only	Breast-feeding and consuming non-milk liquids <sup>1</sup>	Breast-feeding and consuming other milk	Breast-feeding and consuming complementary foods					
0-1	*	*	*	*	*	*	100.0	*	8	*	8
2-3	*	*	*	*	*	*	100.0	*	16	*	16
4-5	*	*	*	*	*	*	100.0	*	14	*	14
6-8	(4.4)	(25.1)	(2.9)	(6.7)	(21.1)	(40.0)	100.0	(95.6)	45	(16.7)	45
9-11	*	*	*	*	*	*	100.0	*	14	*	14
12-17	10.9	16.1	5.2	3.9	5.6	58.3	100.0	89.1	154	21.7	157
18-23	18.2	14.3	6.8	3.0	3.9	53.8	100.0	81.8	119	17.4	122
0-3	(6.0)	(59.5)	(8.1)	(6.2)	(12.9)	(7.2)	100.0	(94.0)	24	(13.5)	24
0-5	3.8	61.7	9.6	6.3	12.2	6.3	100.0	96.2	38	10.8	38
6-9	(4.5)	(20.4)	(5.1)	(5.4)	(18.7)	(45.8)	100.0	(95.5)	55	(16.1)	55
12-15	9.9	14.8	4.1	5.5	8.0	57.7	100.0	90.1	102	25.5	105
12-23	14.1	15.3	5.9	3.5	4.8	56.4	100.0	85.9	273	19.8	279
20-23	(27.3)	(14.0)	(15.4)	(0.5)	(4.4)	(38.3)	100.0	(72.7)	50	(8.7)	50

Note: Breastfeeding status refers to a "24-hour" period (yesterday and last night). Children who are classified as breastfeeding and consuming plain water only consumed no liquid or solid supplements. The categories of not breastfeeding, exclusively breastfed, breastfeeding and consuming plain water, non-milk liquids, other milk, and complementary foods (solids and semi-solids) are hierarchical and mutually exclusive, and their percentages add to 100 percent. Thus children who receive breast milk and non-milk liquids and who do not receive other milk and who do not receive complementary foods are classified in the non-milk liquid category even though they may also get plain water. Any children who get complementary food are classified in that category as long as they are breastfeeding as well. Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed.

<sup>1</sup> Non-milk liquids include juice, juice drinks, clear broth or other liquids

Figure 6\_9.2: Infant feeding practices by age

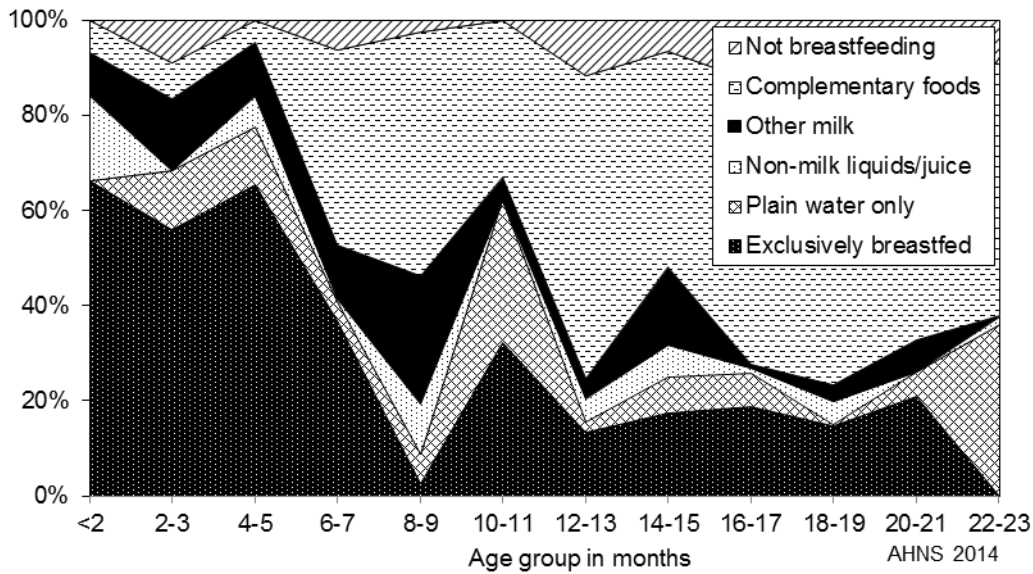
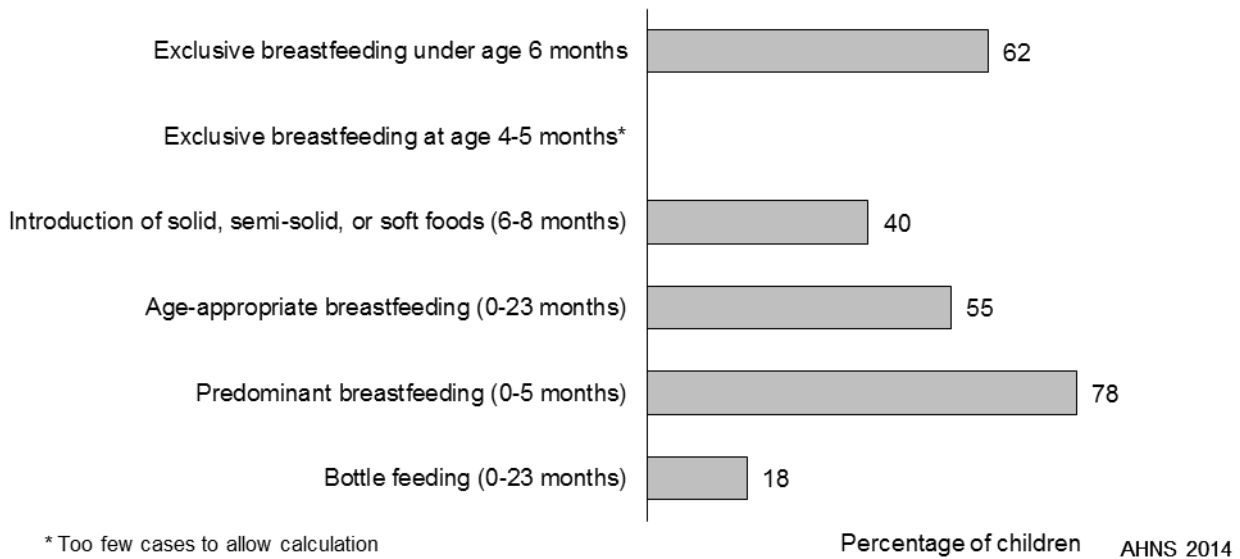


Figure 7\_9.3: IYCF indicators on breastfeeding status



\* Too few cases to allow calculation

### 9.2.3 Median Duration of Breastfeeding

Survey results indicate that the median duration of any breastfeeding (i.e., the length of time in months for which half of children are breastfed) is 23.6 months (table not shown). Overall, the median duration of exclusive breastfeeding for children is 4.8 months, whereas the median duration of predominant breastfeeding (i.e., the period in which an infant receives only water or other non-milk liquids in addition to breast milk) is just under six months (5.7 months). Because the medians are constructed using current breastfeeding status and because the number of children under three years identified in the survey is small, it was not possible to calculate differentials in the median durations of breastfeeding by background characteristics.

### 9.3 Dietary Diversity among Young Children

In the 2014 AHNS, women who had at least one child living with them who was born in 2012 or later were asked questions about the types of liquids and foods the child had consumed during the day or night preceding the interview. Mothers who had more than one child born in 2012 or later were asked questions about the youngest child living with them. Mothers were also asked about the number of times the child had eaten solid or semi-solid food during the period.

The results from these data are subject to a number of limitations. The dietary data on children are subject to recall errors on the mother's part. In addition, the mother may not be able to report fully on the child's intake of food and liquids if the child was fed by other individuals during the period. Despite these problems, the information collected in the survey on the types of foods and liquids consumed by young children is useful in assessing the diversity of children's diets.

#### 9.3.1 Foods and Liquids Consumed by Infants and Young Children

Appropriate nutrition includes feeding children a variety of foods to ensure that nutrient requirements are met. Fruits and vegetables rich in vitamin A should be consumed daily. Although eating a range of fruits and vegetables, especially those rich in vitamin A, is important, studies have shown that plant-based complementary foods by themselves are insufficient to meet the needs for certain micronutrients. Therefore, it has been recommended that meat, poultry, fish, or eggs be eaten daily or as often as possible (WHO, 1998).

Table 9.4 is based on information from mothers about the foods and liquids consumed by their youngest child during the day or night preceding the interview. For all food groups, the proportion of children receiving the food is lower among those who are still breastfed than those who are not being breastfed. This is due in part to the fact that non-breastfeeding children are older than those who are still being breastfed. There are too few children in many age groups to allow meaningful comparisons. Nevertheless, it is interesting to note that only 62 percent of breastfeeding children ages 6-23 months are being given any solid or semi-solid foods, mostly grains (43 percent) and vitamin-A rich fruits and vegetables (25 percent).

**Table 68\_9.4 Foods and liquids consumed by children in the day or night preceding the interview**

Percentage of youngest children under two years of age who are living with the mother by type of foods consumed in the day or night preceding the interview, according to breastfeeding status and age, Afghanistan 2014

Age in months	Liquids				Solid or semi-solid foods									Number of children
	Infant formula	Other milk <sup>1</sup>	Other liquids <sup>2</sup>	Fortified baby foods	Food made from grains <sup>3</sup>	Fruits and vegetables rich in vitamin A <sup>4</sup>	Other fruits and vegetables	Food made from roots and tubers	Food made from legumes and nuts	Meat, fish, poultry	Eggs	Cheese, yogurt, other milk product	Any solid or semi-solid food	
<b>BREASTFEEDING CHILDREN</b>														
0-1	*	*	*	*	*	*	*	*	*	*	*	*	*	8
2-3	*	*	*	*	*	*	*	*	*	*	*	*	*	14
4-5	*	*	*	*	*	*	*	*	*	*	*	*	*	14
6-8	(29.0)	(39.3)	(46.9)	(28.5)	(26.9)	(1.1)	(0.0)	(2.8)	(14.5)	(1.0)	(14.5)	(2.2)	(41.8)	43
9-11	*	*	*	*	*	*	*	*	*	*	*	*	*	14
12-17	15.3	37.2	68.2	4.8	47.9	28.1	8.4	23.5	21.1	20.6	32.0	29.9	65.5	137
18-23	12.8	20.1	52.3	11.9	39.9	33.9	16.4	19.7	13.4	11.3	28.1	19.9	65.8	97
6-23	16.1	31.3	59.2	10.5	42.6	25.3	9.7	18.3	16.7	13.6	27.3	21.2	61.9	292
Total	15.2	29.5	53.9	9.3	38.0	22.8	8.8	16.4	15.2	12.1	24.4	19.2	55.7	329

## NONBREASTFEEDING CHILDREN

0-17	*	*	*	*	*	*	*	*	*	*	*	*	*	21
18-23	*	*	*	*	*	*	*	*	*	*	*	*	*	22
6-23	(29.4)	(46.0)	(79.1)	(9.8)	(55.0)	(41.0)	(14.1)	(23.4)	(16.1)	(24.0)	(33.5)	(21.7)	(69.7)	41
Total	(28.4)	(44.4)	(76.4)	(9.4)	(53.1)	(39.6)	(13.6)	(22.6)	(15.6)	(23.2)	(32.3)	(20.9)	(67.3)	42

Note: Breastfeeding status and food consumed refer to a 24-hour period before the survey. Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

<sup>1</sup> Other milk includes fresh, tinned and powdered cow or other animal milk

<sup>2</sup> Doesn't include plain water

<sup>3</sup> Includes fortified baby food

<sup>4</sup> Includes pumpkin, carrots, squash, sweet potatoes, dark green leafy vegetables, ripe mangoes, and apricots

### 9.3.2 Infant and Young Child Feeding (IYCF) Practices

Appropriate IYCF practices include breastfeeding through age 2, introduction of solid and semisolid foods at age 6 months, and gradual increases in the amount of food given and frequency of feeding as the child gets older. The energy needs of children are based on age-specific total daily energy requirements minus the average energy intake from breast milk. Infants with low breast milk intake need to be fed more frequently than those with high breast milk intake. However, care should be taken that feeding frequencies do not exceed the recommended input from complementary foods because excessive feeding can result in displacement of breast milk (PAHO and WHO, 2003).

According to recommendations, breastfed children age 6-23 months should receive animal-source foods and vitamin A-rich fruits and vegetables daily (PAHO and WHO, 2003). Because first foods almost always include a grain- or tuber-based staple, it is unlikely that young children who eat food from less than three groups will receive both an animal-source food and a vitamin A-rich fruit or vegetable. Therefore, three food groups are considered the minimum number appropriate for breastfed children (Arimond and Ruel, 2004). Breastfed infants age 6-8 months should receive complementary foods two to three times a day, with one or two snacks; breastfed children age 9-23 months should receive meals three to four times a day, with one or two snacks (PAHO and WHO, 2003; WHO, 2008; and WHO, 2010). Non-breastfed children age 6-23 months should receive milk or milk products two or more times a day to ensure that their calcium needs are met. In addition, they need animal-source foods and vitamin A-rich fruits and vegetables. Four food groups are considered the minimum number appropriate for non-breastfed young children. Non-breastfed children age 12-23 months should be fed meals four to five times each day, with one or two snacks (WHO, 2005; WHO, 2008; and WHO, 2010). Results are shown in Table 9.5.



**Table 69\_9.5 Infant and young child feeding (IYCF) practices**

Percentage of youngest children age 6-23 months living with their mother who are fed according to three IYCF feeding practices based on breastfeeding status, number of food groups, and times they are fed during the day or night preceding the survey, by background characteristics, Afghanistan 2014

Background characteristic	Among breastfed children 6-23 months, percentage fed:				Among non-breastfed children 6-23 months, percentage fed:				Among all children 6-23 months, percentage fed:					
	4+ food groups <sup>1</sup>	Minimum meal frequency <sup>2</sup>	Both 4+ food groups and minimum meal frequency	Number of children 6-23 months breastfed	Milk or milk products <sup>3</sup>	4+ food groups <sup>1</sup>	Minimum meal frequency <sup>4</sup>	With 3 IYCF practices <sup>5</sup>	Number of non-breastfed children 6-23 months	Breast milk, or milk	4+ food groups <sup>1</sup>	Minimum meal frequency <sup>7</sup>	With 3 IYCF practices	Number of all children 6-23 months
<b>Age in months</b>														
6-8	(0.9)	(72.2)	(0.9)	43	*	*	*	*	2	(95.6)	(0.9)	(69.1)	(0.9)	45
9-11	*	*	*	14	*	*	*	*	1	*	*	*	*	14
12-17	23.0	49.9	20.4	137	*	*	*	*	17	94.8	23.8	53.2	20.0	154
18-23	16.8	44.8	12.4	97	*	*	*	*	22	92.7	18.4	48.4	14.5	119
<b>Sex</b>														
Male	12.3	55.3	9.2	157	*	*	*	*	24	94.9	14.6	58.1	11.3	181
Female	22.5	47.5	19.4	135	*	*	*	*	17	93.8	22.6	48.6	18.7	152
<b>Mother's education</b>														
No education	17.8	52.8	14.9	242	(50.9)	(24.2)	(65.9)	(19.7)	38	93.3	18.7	54.6	15.5	280
Primary	*	*	*	17	*	*	*	*	1	100.0	(22.8)	(48.7)	(17.9)	18
Secondary	(8.2)	(46.1)	(4.7)	30	*	*	*	*	2	100.0	(11.2)	(49.0)	(4.5)	32
More than secondary	*	*	*	3	*	*	*	*	0	*	*	*	*	4
Total	17.0	51.7	13.9	292	(54.5)	(27.3)	(68.4)	(20.5)	41	94.4	18.3	53.8	14.7	333

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

<sup>1</sup> Food groups: a. infant formula, milk other than breast milk, cheese or yogurt or other milk products; b. foods made from grains, roots, and tubers, including porridge and fortified baby food from grains; c. vitamin A-rich fruits and vegetables (and red palm oil); d. other fruits and vegetables; e. eggs; f. meat, poultry, fish, and shellfish (and organ meats); g. legumes and nuts.

<sup>2</sup> For breastfed children, minimum meal frequency is receiving solid or semi-solid food at least twice a day for infants 6-8 months and at least three times a day for children 9-23 months

<sup>3</sup> Includes two or more feedings of commercial infant formula, fresh, tinned, and powdered animal milk, and yogurt

<sup>4</sup> For non-breastfed children age 6-23 months, minimum meal frequency is receiving solid or semi-solid food or milk feeds at least four times a day

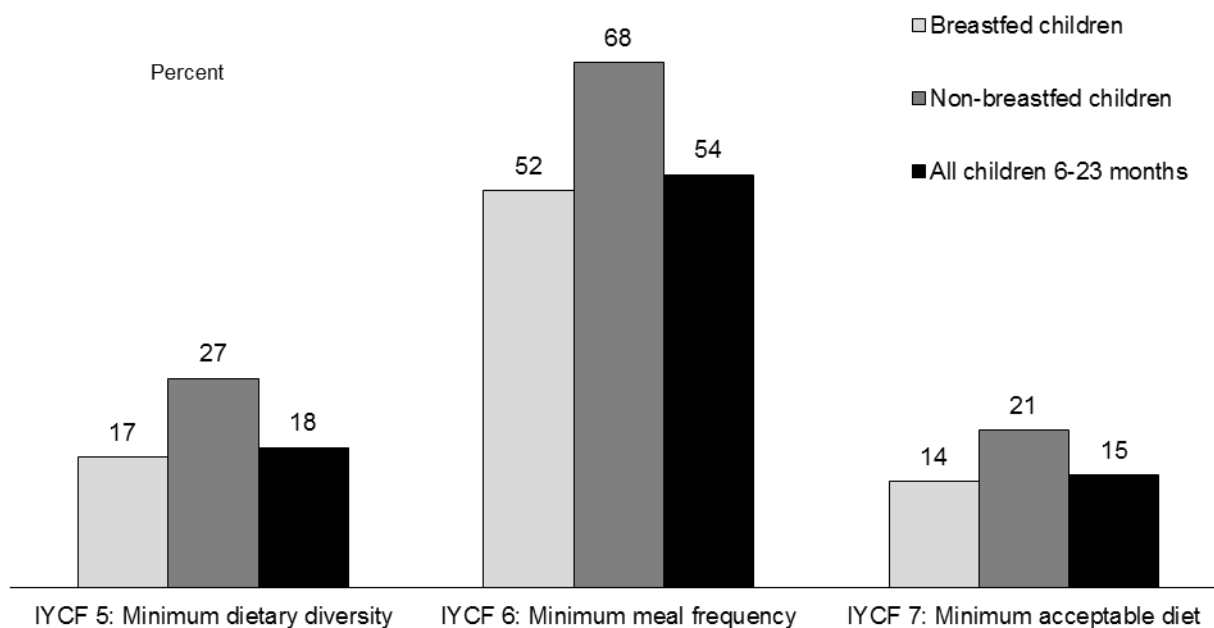
<sup>5</sup> Non-breastfed children age 6-23 months are considered to be fed with a minimum standard of three Infant and Young Child Feeding Practices if they receive other milk or milk products at least twice a day, receive the minimum meal frequency, and receive solid or semi-solid foods from at least four food groups not including the milk or milk products food group

<sup>6</sup> Breastfeeding, or not breastfeeding and receiving two or more feedings of commercial infant formula, fresh, tinned and powdered animal milk, and yogurt

<sup>7</sup> Children are fed the minimum recommended number of times per day according to their age and breastfeeding status as described in footnotes 2 and 4

The results indicate that 94 percent of children age 6-23 months living with their mother received breast milk or breast milk substitutes during the day or night preceding the interview. Only 18 percent of children had an adequately diverse diet—that is, they had been given foods from the appropriate number of food groups—and 54 percent had been fed the minimum number of times appropriate for their age. In summary, the feeding practices of only 15 percent of children age 6-23 months meet the minimum standards with respect to all three IYCF practices; this is almost identical to the national average of 12 percent found in the 2013 National Nutrition Survey (MOPH and UNICEF, 2014). Differences in feeding practices by background characteristics should be interpreted with caution because of the small number of children reported on in the different groups. The IYCF indicators for minimum acceptable diet by breastfeeding status among children age 6-23 months are summarized in Figure 9.4.

Figure 8\_9.4: IYCF indicators on minimum acceptable diet



AHNS 2014

## 9.4 Micronutrient Intake and Supplementation among Children

Micronutrient deficiency is a major contributor to childhood morbidity and mortality. Micronutrients are available in foods and can also be provided through direct supplementation. Breastfeeding children benefit from supplements given to the mother. Iron deficiency is one of the primary causes of anemia, which has serious health consequences for both women and children. Vitamin A is an essential micronutrient for the immune system and plays an important role in maintaining the epithelial tissue in the body. Severe vitamin A deficiency (VAD) can cause eye damage and is the leading cause of childhood blindness. VAD also increases the severity of infections such as measles and diarrheal disease in children and slows recovery from illness. VAD is common in dry environments where fresh fruits and vegetables are not readily available. Vitamin A supplementation is an important tool in preventing VAD among young children.

Information was collected in the AHNS on food consumption during the day and night preceding the interview among the youngest children under age 2 living with their mothers; these data are useful in assessing the extent to which children are consuming food groups rich in two key micronutrients—vitamin A and iron—in their daily diet. In addition, the survey included questions designed to ascertain whether young children had received vitamin A supplements in the 6 months before the survey, iron supplements in the seven days preceding the survey, or deworming medication in the six months preceding the survey.

Table 9.6 shows the intake of foods rich in vitamin A and iron by the youngest children age 6-23 months living with their mothers. The table shows that 41 percent of children consumed vitamin A-rich foods in the 24 hours preceding the interview, and 32 percent consumed iron-rich foods. Intake of these two micronutrients is slightly higher among male children in the program areas than among female children.

**Table 70\_9.6 Micronutrient intake among children**

Among youngest children age 6-23 months who are living with their mother, the percentages who consumed vitamin A-rich and iron-rich foods in the day or night preceding the survey, and among all children 6-59 months, the percentages who were given vitamin A supplements in the six months preceding the survey, who were given iron supplements in the past seven days, and who were given deworming medication in the six months preceding the survey, and among all children age 6-59 months who live in households that were tested for iodized salt, the percentage who live in households with iodized salt, by background characteristics, Afghanistan 2014

Background characteristic	Among youngest children age 6-23 months living with the mother:			Among all children age 6-59 months:			
	Percentage who consumed foods rich in vitamin A in last 24 hours <sup>1</sup>	Percentage who consumed foods rich in iron in last 24 hours <sup>2</sup>	Number of children	Percentage given vitamin A supplements in last 6 months	Percentage given iron supplements in last 7 days	Percentage given deworming medication in last 6 months <sup>3</sup>	Number of children
<b>Age in months</b>							
6-8	(15.9) *	(14.9) *	45	(28.4) *	(6.5) *	(24.3) *	45
9-11			14				14
12-17	46.1	38.0	154	48.7	31.4	16.6	157
18-23	45.1	32.1	119	36.9	27.2	13.8	122
24-35	na	na	na	37.2	37.5	29.7	220
36-47	na	na	na	39.0	19.7	25.3	190
48-59	na	na	na	39.7	28.9	37.9	200
<b>Sex</b>							
Male	43.2	34.0	181	37.4	30.2	23.8	477
Female	37.5	29.3	152	40.9	25.9	27.9	471
<b>Breastfeeding status</b>							
Breastfeeding	37.9	31.2	292	40.5	29.7	19.7	403
Not breastfeeding	(59.8)	(37.0)	41	38.2	26.8	30.4	546
<b>Mother's age at birth</b>							
15-19	*	*	17	(33.0)	(27.4)	(16.8)	26
20-29	36.8	27.5	186	38.3	32.8	23.2	444
30-39	49.9	41.8	122	42.5	22.9	29.4	399
40-49	*	*	8	29.6	27.7	26.0	80
<b>Mother's education</b>							
No education	41.9	34.0	280	35.4	27.1	23.8	829
Primary	(50.3)	(33.4)	18	53.8	31.9	43.3	49
Secondary	(25.1)	(13.0)	32	73.0	30.9	35.1	62
More than secondary	*	*	4	*	*	*	8
Total	40.6	31.9	333	39.2	28.0	25.9	949

Note: Information on vitamin A is based on both mother's recall and the immunization card (where available). Information on iron supplements and deworming medication is based on the mother's recall. Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

na = Not applicable

<sup>1</sup> Includes meat (and organ meat), fish, poultry, eggs, pumpkin, squash, carrots, sweet potatoes, dark green leafy vegetables, mango, and apricots

<sup>2</sup> Includes meat (including organ meat), fish, poultry and eggs

<sup>3</sup> Deworming for intestinal parasites is commonly done for helminthes and for schistosomiasis.

Almost four in ten children age 6-59 months received a high-dose vitamin A supplement in the 6 months before the survey. Variations by background characteristics are not large except that the proportion of children who received vitamin A supplements increases substantially with education of the mother, more than doubling from 35 percent among children whose mothers have no education to 73 percent of those who have been to secondary school.

Slightly over one-quarter of children age 6-59 months received iron supplements in the seven days before the survey (28 percent). Almost the same percentage of children were reported to have received deworming medicine in the six months preceding the survey (26 percent).

## 9.5 Micronutrient Intake among Mothers

Adequate micronutrient intake by women has important benefits for both women and their children. Pregnancy and childbirth can reduce the store of vitamin A in a woman's body, so in many countries, women are encouraged to get high-dose supplements after delivery. As mentioned earlier, pregnant women are also more likely to be anemic than other women. Iron status among pregnant women can be improved by means of iron supplements as well as by increased consumption of iron-rich foods. Table 9.7 shows the percentage of women who gave birth during the five years prior to the survey who received a high-dose vitamin A supplement postpartum and the percent distribution of women by the number of days they took iron tablets during the pregnancy for their last-born child.

Forty-three percent of women who had a birth in the five years before the survey received a postpartum vitamin A supplement. The likelihood of receiving such a supplement increases with education level of the woman.

Over half of women did not take iron supplements at all during the pregnancy for their last birth. The vast majority of women who took supplements took them for less than 60 days (36 percent of women with a birth in the past five years). Only 3 percent of women took iron supplements for the recommended period of time (90 days or more).

**Table 71\_9.7 Micronutrient intake among mothers**

Among women age 15-49 with a child born in the past five years, the percentage who received a vitamin A dose in the first two months after the birth of the last child and the percent distribution by number of days they took iron tablets or syrup during the pregnancy of the last child, by background characteristics, Afghanistan 2014

Background characteristic	Percentage who received vitamin A dose postpartum <sup>1</sup>	Number of days women took iron tablets or syrup during pregnancy of last birth					Don't know/missing	Total	Number of women
		None	<60	60-89	90+				
<b>Age</b>									
15-19	(37.0)	(72.2)	(14.5)	(5.9)	(5.8)	(1.7)	100.0	23	
20-29	44.5	49.7	39.9	6.1	3.3	1.0	100.0	297	
30-39	41.8	55.6	32.0	8.3	2.4	1.7	100.0	280	
40-49	47.4	57.3	39.5	1.4	1.8	0.0	100.0	73	
<b>Education</b>									
No education	40.9	54.7	35.1	6.0	2.9	1.3	100.0	586	
Primary	51.9	39.1	55.1	4.0	0.7	1.1	100.0	35	
Secondary	67.4	52.7	30.8	14.4	2.2	0.0	100.0	47	
Higher	*	*	*	*	*	*	100.0	4	
Total	43.4	53.7	35.7	6.5	2.8	1.2	100.0	673	

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

<sup>1</sup> In the first two months after delivery of last birth

**Key Findings**

- Smoking is virtually non-existent among ever-married women age 15-49
- Only 27 percent of ever-married women say they have ever had their blood pressure tested. Four percent have been diagnosed with hypertension in the previous 12 months.
- 3 percent of ever-married women have been diagnosed as having diabetes in the 12 months before the survey.
- 8 percent of women have ever been diagnosed with high cholesterol; 44 percent are taking medication.
- Only 3 percent of ever-married women have had a mammogram and 45 percent have had a gynecological exam.
- Just under half of women live in areas covered by CHWs.
- Family and friends are the main source of health information among ever-married women age 15-49.

**T**his chapter focuses on other health issues among women age 15-49, including smoking, screening for chronic diseases, and sources of health information. In interpreting the data, it is important to remember that no biological testing was included in the survey, so all results are as reported by the individual women interviewed.

**10.1 Tobacco Use among Women**

Tobacco use has been shown to adversely affect both the health of users and those around them and is considered by the World Health Organization to be the primary cause of preventable deaths worldwide (WHO, 2011b). The 2014 AHNS collected information on women's tobacco use. Ever-married women were asked if they currently smoke any tobacco products and if so, whether they smoke daily, how old they were when they first started smoking daily, how long ago they first started smoking daily, and how many cigarettes/cigars/pipes they smoke each day.

Results indicate that smoking is virtually non-existent among ever-married women in the CAHSS program areas in Afghanistan. Ninety-nine percent of ever-married women reported that they do not use tobacco products (table not shown). Given the deleterious effects of smoking, this is very positive news.

**10.2 Hypertension**

In the survey, women were asked a series of questions to assess the level of and response to hypertension or high blood pressure. Women were first asked if they had ever had their blood pressure measured by a doctor or other health worker. If so, they were asked if they had ever been told by a health worker that they had raised blood pressure or hypertension and if so, whether they were told on two or more occasions and whether they were told in the 12 months before the survey. Finally, all those who were ever diagnosed as having hypertension were asked if they were currently taking specific measures to lower their blood pressure, including taking medicine, controlling weight, cutting down on salt intake, exercising, and cutting down on alcohol intake. Results are shown in Tables 10.1 and 10.2.

As shown in Table 10.1, only slightly over one-quarter of ever-married women reported having ever had their blood pressure measured. Six percent of ever-married women age 15-49 say they have been told they had hypertension. Most of them (4 percent of all ever-married women) have been told at least twice that they had hypertension and 4 percent say they have been told this in the 12 months before the

survey. The prevalence of hypertension fluctuates with age and is highest among the small number of ever-married women age 15-19. The level of hypertension decreases slightly as education level increases.

**Table 72\_10.1 Hypertension testing**

Percentage of ever-married women age 15-49 who have ever had their blood pressure tested and percentage who have been told by a health worker that they have hypertension: ever, on two or more occasions, and in the 12 months before the survey, by background characteristics, Afghanistan 2014

Background characteristic	Ever had blood pressure measured	Told by doctor/health worker that she had hypertension			Number of women
		Ever	Two times or more	In the past 12 months	
<b>Age</b>					
15-19	28.0	13.5	8.6	8.6	38
20-24	23.2	5.8	5.8	3.6	200
25-29	29.6	5.1	3.1	2.6	153
30-34	29.2	7.1	4.6	4.4	189
35-39	21.1	3.1	2.4	2.0	186
40-44	37.4	8.7	4.9	4.9	101
45-49	22.8	4.9	3.6	2.8	107
<b>Education</b>					
No education	27.4	6.3	4.6	3.7	845
Primary	13.4	3.7	2.9	2.7	50
Secondary	26.6	2.4	2.4	2.4	68
Higher	*	*	*	*	10
Total	26.6	5.9	4.3	3.5	974

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

Table 10.2 shows that almost 3 in 4 women who were ever diagnosed with hypertension were taking medication to reduce their blood pressure, with an even higher proportion of those diagnosed more recently. About half of women with high blood pressure said they were cutting down their intake of salt. Other measures women take to reduce their blood pressure include controlling or losing weight (15 percent of women ever diagnosed with hypertension), exercising (11 percent), and somewhat surprisingly, stopping smoking (12 percent).

### 10.3 Diabetes

As for hypertension, ever-married women were asked a series of questions to assess the level of and response to diabetes or raised blood sugar. Women were first asked if they had ever had their blood sugar measured by a doctor or other health worker. If so, they were asked if they had ever been told by a health worker that they had raised blood sugar or diabetes and if so, whether they were told in the 12 months before the survey. Those who were diagnosed with diabetes in the previous 12 months were asked if they had taken insulin or other prescribed medication for high blood sugar in the previous 24 hours.

Survey results show that only 8 percent of ever-married women have had their blood sugar measured at some point in their lives (Table 10.3). The proportion of women who report ever having had their blood sugar measured varies inconsistently with age and education.

**Table 73\_10.2 Actions taken to lower hypertension**

Among ever-married women age 15-49 who have been told they have hypertension ever, at least twice, and in the 12 months before the survey, percentage who are currently taking specific actions to lower their hypertension, Afghanistan 2014

Action	Told by doctor/health worker that she had hypertension		
	Ever	Two times or more	In the past 12 months
Taking prescribed medicine	73.0	(88.4)	(91.4)
Controlling/losing weight	15.0	(12.8)	(15.5)
Cutting down on salt intake	48.4	(54.7)	(55.5)
Exercising	10.7	(12.3)	(14.9)
Stopping smoking	11.6	(15.3)	(18.4)
Number of women	58	42	34

Note: Figures in parentheses are based on 25-49 unweighted cases.

**Table 74\_10.3 Diabetes testing**

Percentage of ever-married women age 15-49 who have ever had their blood sugar tested and percentage who have been told by a health worker that they have raised blood sugar or diabetes: ever and in the 12 months before the survey, by background characteristics, Afghanistan 2014

Background characteristic	Ever had blood sugar measured	Told by doctor/health worker that she had diabetes		Number of women
		Ever	In the past 12 months	
<b>Age</b>				
15-19	12.1	4.5	1.0	38
20-24	8.0	4.9	4.9	200
25-29	4.3	2.5	1.7	153
30-34	11.4	6.0	5.3	189
35-39	4.8	1.2	0.2	186
40-44	13.2	7.6	7.6	101
45-49	9.9	1.0	1.0	107
<b>Education</b>				
No education	8.4	4.2	3.5	845
Primary	1.8	0.8	0.8	50
Secondary	11.2	0.6	0.6	68
Higher	*	*	*	10
Total	8.4	3.9	3.3	974

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

Four percent of ever-married women age 15-49 have ever been told by a health professional that they have diabetes or raised blood sugar and 3 percent have been diagnosed in the 12 months before the survey. Rates are erratic by age and education.

Of the small number (32) of women who were told in the past 12 months that they had diabetes, 72 percent said they were taking insulin or other prescribed medication for the disease (table not shown).

## 10.4 High Cholesterol

In the 2014 AHNS, ever-married women were asked if they had ever been told by a health worker that they had high cholesterol and if so, whether they had been treated in the previous two weeks for high cholesterol with medicines prescribed by a doctor or other health worker.

Survey results show that only 8 percent of women have ever been diagnosed with high cholesterol (Table 10.4). The prevalence of high cholesterol shows a slight tendency to increase with age, being highest (15 percent) among women age 45-49, although the pattern is quite erratic. High cholesterol appears to decrease as education increases. It should be noted that these differences could be due in part or entirely to differences in the extent of testing for high cholesterol.

Among women who had ever been diagnosed with high cholesterol, 44 percent reported that they had taken prescribed medication in the two

**Table 75\_10.4 Prevalence of high cholesterol**

Percentage of ever-married women age 15-49 who have ever been told by a health worker that they have high cholesterol, by background characteristics, Afghanistan 2014

Background characteristic	Percentage	Number of women
<b>Age</b>		
15-19	4.5	38
20-24	10.0	200
25-29	4.9	153
30-34	8.1	189
35-39	3.9	186
40-44	9.8	101
45-49	14.5	107
<b>Education</b>		
No education	8.4	845
Primary	6.5	50
Secondary	2.4	68
Higher	*	10
Total	7.9	974

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

weeks before the survey (table not shown).

## 10.5 Breast and Cervical Cancer Screening

To assess knowledge and use of breast cancer screening, women interviewed in the 2014 AHNS were asked if they had ever heard of a machine that can check a woman's breast to see if she has breast cancer and if so, whether they had ever had a test with such a machine (mammogram).

Results indicate that only about one in five ever-married women have heard of a mammogram and only 3 percent have ever had a mammogram (Table 10.5). Both knowledge and use of mammograms is highest among women age 15-19 and lowest among those in their late 20s. Women who attended secondary school are more likely to have heard of mammography as well as to have ever had a mammogram.

Table 10.5 shows that just over one-third of ever-married women age 15-49 have ever heard of cervical cancer. Awareness of this cancer tends to decrease with increasing age and increase with increasing education level.

Just under half of ever-married women (45 percent) have ever had a gynecological examination. The proportion fluctuates with age of the woman. Women with no education are more likely to have had a gynecological exam than women with only primary or secondary school.

**Table 76\_10.5 Breast and cervical cancer screening**

Among ever-married women age 15-49, percentage who have ever heard of a breast cancer screening machine, percentage who have ever had a mammogram, percentage who have ever heard of cervical cancer, and percentage who have ever had a gynecological examination, by background characteristics, Afghanistan 2014

Background characteristic	Percentage who ever heard of breast cancer screening machine (mammogram)	Percentage who ever had a mammogram	Percentage who ever heard of cervical cancer	Percentage who have ever had a gynecological examination	Number of women
<b>Age</b>					
15-19	25.3	11.0	39.6	43.2	38
20-24	24.3	4.2	42.1	36.9	191
25-29	12.0	0.3	35.3	45.6	150
30-34	14.3	1.2	36.7	50.1	181
35-39	21.4	1.2	34.3	42.5	180
40-44	14.5	2.9	30.1	61.3	98
45-49	16.9	7.8	27.1	27.3	93
<b>Education</b>					
No education	14.5	2.5	33.3	45.4	805
Primary	41.8	0.0	44.4	30.8	47
Secondary	36.8	4.6	51.7	30.8	68
Higher	*	*	*	*	10
Total	18.5	3.3	36.0	45.1	974

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.



## 10.6 Contact with Health Care Providers

Contacts with health care workers can be an important source of education about health issues. In Afghanistan, there is a system of community health workers (CHW). CHWs work on a voluntary basis to disseminate health-related information for health promotion among community members.

According to survey results, just under half of ever-married women living in the CAHSS program areas say there is a CHW in their village. Thirty percent of women (or almost two-thirds of those with CHWs) say that the CHW visited them in the 12 months before the survey. The proportion of women who report having a CHW in their village as well as the proportion reporting that the CHW visited them in the 12 months before the survey increase with education of the woman.

Seventy-one percent of ever-married women report that they visited a health care facility in the 12 months before the survey. Women age 45-49 are less likely than younger women to have visited a facility.

**Table 77\_10.6 Contact of women with health care providers**

Among ever-married women age 15-49, percentage who have a community health worker (CHW) in their village, the percentage who say the CHW visited them in the previous 12 months, and the percentage who visited a health facility in the previous 12 months, by background characteristics, Afghanistan 2014

Background characteristic	Percentage who say there is a CHW in their village	Percentage who say the CHW visited them in the last 12 months	Percentage who visited a health facility in the last 12 months	Number of women
<b>Age</b>				
15-19	51.6	26.0	76.9	38
20-24	51.8	38.9	74.7	200
25-29	41.2	23.5	71.2	153
30-34	46.3	27.6	71.6	189
35-39	54.1	34.6	70.2	186
40-44	37.0	25.4	74.7	101
45-49	43.9	21.8	55.7	107
<b>Education</b>				
No education	44.7	27.3	71.1	845
Primary	57.7	40.1	57.8	50
Secondary	67.6	52.7	72.0	68
Higher	*	*	*	10
Total	47.1	29.7	70.7	974

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

Women who said they were visited by their CHW in the 12 months before the survey were asked what topics were discussed during the visit. As shown in Table 10.7, the main topics were mother's health (59 percent), children's health (46 percent) and family planning (43 percent). Water and sanitation were the next most commonly discussed topics (24 percent), followed by antenatal care (21 percent), breastfeeding (18 percent), and birth preparedness (10 percent).

**Table 78\_10.7 Topics discussed with the CHW**

Among ever-married women age 15-49 who were visited by the community health worker (CHW) in the 12 months before the survey, percentage who say they discussed particular topics, Afghanistan 2014

Topic	Percentage
Family planning	43.0
Mother's health	58.8
Child's health/immunization	46.1
Breastfeeding	17.6
Water/sanitation	24.3
Antenatal care	21.0
Birth preparedness	9.5
Number of women	289

## 10.7 Sources of Health Information

Women who were interviewed in the 2014 AHNS were asked what their main source of information about health issues was. As shown in Table 10.8, the largest proportion of ever-married women (43 percent) said that family and friends were their main source of health information. The next most common source of health information is television, mentioned by 28 percent of women, followed closely by radio (22 percent). Four percent of women said their main source of health information is the community health worker (CHW), while another 4 percent mentioned doctors and nurses. Newspapers and magazines were hardly mentioned as a main source of health information.

Younger ever-married women rely more on radio and television as sources of health information than older women, who are more likely to rely on friends and family. The proportion of ever-married women who report that family and friends are their main source of health information decreases as education level increases. Radio is the most commonly reported source of health information among women who have been to secondary school, whereas television is the most common source among women with primary school only.

**Table 79\_10.8 Source of health information**

Percent distribution of ever-married women age 15-49 by main source of health information, according to background characteristics, Afghanistan 2014

Background characteristic	Radio	Television	News-paper/magazine	Community health worker	Doctors/Nurses	Family/Friends	Other	Total	Number of women
<b>Age</b>									
15-19	35.2	28.3	0.0	1.0	2.0	33.6	0.0	100.0	38
20-24	25.0	38.3	1.6	0.8	2.4	31.9	0.0	100.0	200
25-29	12.2	24.0	0.0	9.0	5.5	49.3	0.0	100.0	153
30-34	27.3	27.1	0.0	2.9	2.2	40.4	0.1	100.0	189
35-39	21.4	26.3	0.0	3.8	3.0	45.4	0.0	100.0	186
40-44	14.0	27.0	0.0	3.7	6.4	48.5	0.4	100.0	101
45-49	21.3	20.5	0.0	2.6	4.3	51.2	0.0	100.0	107
<b>Education</b>									
No education	20.9	25.5	0.0	3.8	3.6	46.2	0.0	100.0	845
Primary	9.3	59.4	0.0	1.7	2.7	26.1	0.8	100.0	50
Secondary	41.4	35.1	0.4	2.4	3.4	17.4	0.0	100.0	68
Higher	*	*	*	*	*	*	*	100.0	10
Total	21.6	28.1	0.3	3.6	3.6	42.8	0.1	100.0	974

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

**Key Findings**

- Less than one in five households reported that someone had heard a message on ECD in the three months before the survey
- Early childhood education is almost non-existent in the sampled areas; less than one percent of children age three and four years were attending an early childhood education program such as kindergarten or community child care
- Only 1 percent of children under 5 live in households with three or more children’s books
- Almost half of children under five were left with inadequate care in the week before the survey, either left alone for more than one hour (37 percent) and/or left in the care of another child under 10 years old for more than one hour (36 percent).

This chapter focuses on issues related to early childhood development (ECD), including coverage of ECD messages, the proportion of young children who are attending pre-school, and activities and materials in the house that can contribute to stimulation and learning of young children. Finally, data are presented on the extent to which young children are left alone or under inadequate care.

**11.1 Messages on Early Childhood Development**

In the AHNS survey, respondents to the household questionnaire were asked if anyone in the household had heard a message about early childhood development in the three months before the survey. Although this approach to gathering data on the coverage of ECD messages is simple, it underestimates coverage because the household respondent may not know about messages heard by other household members.

Nevertheless, results in Table 11.1 indicate that fewer than one in five households reported that someone had heard a message on ECD in the three months before the survey. Among households in which a message was heard, the most important medium for ECD messages is health providers, followed by television and schools. Community workers and the radio are also sources of ECD messages. However, the internet and leaflets/brochures are not important sources of ECD messages.

**Table 80\_11.1 Coverage of messages on early childhood development**

Percentage of households in which anyone has heard a message on early childhood development (ECD) in the three months before the survey and among those households, percentage who heard a message through a specific source, Afghanistan 2014

	Among all households		Among households in which a message was heard, source of ECD message							Number of households
	Percentage in which anyone heard an ECD message in the past three months	Number of households	School	Health provider	Community worker	Internet	TV	Radio	Leaflet/poster/brochure	
Total	18.9	1,002	42.7	70.8	12.7	0.3	43.7	10.5	1.3	190

## 11.2 Early Childhood Education

Research indicates that exposure to learning activities at a young age can have long-lasting effects on a child's development. However, survey results show that early childhood education has not caught on in the program areas of Afghanistan. Less than one percent of children age three and four years were attending some sort of organized early childhood education program such as kindergarten, community child care, etc. (table not shown). This extremely low level is true for males and females and for all categories of maternal education.

## 11.3 Early Childhood Learning Activities

In the AHNS survey, information was asked separately for all children under five as to whether, in the three days before the survey, an adult member of the household engaged the child in any of six different kinds of activities. The activities asked about were:

- (a) reading books to or looking at picture books with the child,
- (b) telling stories to the child
- (c) singing songs to or with the child
- (d) taking the child outside the home, compound yard or enclosure
- (e) playing with the child, and
- (f) naming, counting or drawing things to or with the child.

As shown in Table 11.2, adults engaged only 15 percent of three- and four-year-old children (36-59 months) in four or more of the activities asked about in the survey. The mean number of activities engaged in was 3.3. Differences by background characteristics are small.

**Table 81\_11.2 Activities that support learning**

Percentage of de facto children age 3-4 years with whom an adult household member engaged in four or more activities that promote learning and school readiness and mean number of such activities during the three days before the survey, by background characteristics Afghanistan 2014

Background characteristic	Among children age 3-4 years		
	Percentage with whom adult household members engaged in four or more activities <sup>1</sup>	Mean number of activities in which any adult household member engaged with the child	Number of children age 3-4 years
<b>Child's age</b>			
3 years	14.4	3.2	190
4 years	15.4	3.4	208
<b>Child's sex</b>			
Male	14.9	3.3	183
Female	15.0	3.3	215
<b>Mother's education</b>			
No education	14.3	3.1	349
Primary	*	*	10
Secondary	(17.3)	(4.6)	22
Higher	*	*	4
Total	14.9	3.3	398

Note: Figures in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed. The maximum number of activities is six. The activities include: (a) reading books to or looking at picture books with the child, (b) telling stories to the child, (c) singing songs to or with the child, (d) taking the child outside the home, compound yard or enclosure, (e) playing with the child, and (f) naming, counting or drawing things to or with the child

Table 11.3 shows information for children under five about the number of books and types of toys available in their households. Results show that only 1 percent of children under 5 live in households that have three or more children's books; only 1 in 1,000 children live in households with ten or more children's books.

With regard to toys, about 6 in 10 children under five play with household objects or objects found outside, while 41-45 percent play with homemade toys and/or manufactured toys. About half of children under five play with two or more types of playthings. As expected, children age 2-4 years are more likely than those age 0-1 to play with all types of playthings.

**Table 82\_11.3 Learning materials**

Percentage of de facto children under age five in households with three or more and with ten or more children's books and percentage who play with various types of toys, by background characteristics, Afghanistan 2014

Background characteristic	Household has for the child		Child plays with:				Number of children under 5
	Three or more children's books	Ten or more children's books	Homemade toys	Toys from a shop/manufactured toys	Household objects/objects found outside	Two or more types of playthings	
<b>Age</b>							
0-1 year	0.2	0.1	26.5	26.6	38.2	26.6	378
2-4 years	2.0	0.2	55.6	50.4	71.0	59.7	618
<b>Child's sex</b>							
Male	1.8	0.1	45.2	44.1	58.6	49.1	501
Female	0.8	0.2	43.9	38.6	58.5	45.1	495
<b>Mother's education</b>							
No education	1.2	0.1	47.7	42.1	56.9	48.1	846
Primary	3.1	0.5	35.6	28.0	73.6	37.9	56
Secondary	1.8	0.4	13.5	33.2	66.5	33.8	67
Higher	*	*	*	*	*	*	11
Total	1.3	0.1	44.6	41.4	58.5	47.2	996

Note: Since information is taken from the household questionnaire, mother's education is not available for all children under five. An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

## 11.4 Inadequate Care of Children under Five

In the AHNS survey, an attempt was made to assess how frequently young children might be left alone or in the care of someone too young to adequately watch them. Respondents to the household questionnaire were asked two questions for each of the children under 5 listed in the household roster: "Sometimes adults taking care of children have to leave the house to go shopping or wash clothes or for other reasons and have to leave young children. On how many days in the past week, was (NAME) left alone for more than one hour? On how many days in the past week, was (NAME) left with another child under 10 years old for more than one hour?" Results are shown in Table 11.4.

Data indicate that almost half (45 percent) of children under five were left with inadequate care in the week before the survey. Thirty-seven percent were reported to have been left alone for more than one hour, while 36 percent were reported to have been left in the care of another child under 10 years old for more than one hour. As might be expected, older children (age 2-4) are more likely than younger children to have been left alone or in the care of another child.

**Table 83\_11.4 Inadequate care**

Percentage of children under age five who were left alone or left in the care of another child under ten years of age for more than one hour during the past week, by background characteristics, Afghanistan 2014

Background characteristic	Left alone in the past week	Left in the care of another child younger than 10 years of age in the past week	Left with inadequate care in the past week	Number of children under 5
<b>Age</b>				
0-1 year	26.0	19.8	31.3	378
2-4 years	44.2	45.1	54.0	619
<b>Child's sex</b>				
Male	37.0	34.4	45.0	502
Female	37.6	36.6	45.8	495
<b>Mother's education</b>				
No education	38.2	36.6	46.7	846
Primary	25.1	26.2	36.1	56
Secondary	31.7	23.3	35.1	68
Higher	*	*	*	12
Total	37.3	35.5	45.4	997

Note: An asterisk denotes a figure based on fewer than 25 unweighted cases that has been suppressed.

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## APPENDIX A

### SAMPLE DESIGN

Table A.1 Sample implementation

Percent distribution of households and eligible women by results of the household and individual interviews, and household, eligible women and overall women response rates, according to region (unweighted), Afghanistan 2014

Result	Total
<b>Selected households</b>	
Completed (C)	95.4
Household present but no competent respondent at home (HP)	1.0
Refused (R)	0.8
Dwelling not found (DNF)	0.0
Household absent (HA)	2.1
Dwelling vacant/address not a dwelling (DV)	0.2
Other (O)	0.6
Total	100.0
Number of sampled households	1,050
Household response rate (HRR) <sup>1</sup>	98.2
<b>Eligible ever-married women</b>	
Completed (EWC)	97.0
Not at home (EWNH)	2.7
Refused (EWR)	0.1
Other (EWO)	0.2
Total	100.0
Number of women	1,009
Eligible women response rate (EWRR) <sup>2</sup>	97.0
Overall women response rate (ORR) <sup>3</sup>	95.3

<sup>1</sup> Using the number of households falling into specific response categories, the household response rate (HRR) is calculated as:

$$\frac{100 * C}{C + HP + P + R + DNF}$$

<sup>2</sup> The eligible women response rate (EWRR) is equivalent to the percentage of interviews completed (EWC)

<sup>3</sup> The overall women response rate (OWRR) is calculated as:  
 $OWRR = HRR * EWRR/100$

## APPENDIX B

# ESTIMATES OF SAMPLING ERRORS

The estimates from a sample survey are affected by two types of errors: nonsampling errors and sampling errors. Nonsampling errors are the results of mistakes made in implementing data collection and data processing, such as failure to locate and interview the correct household, misunderstanding of the questions on the part of either the interviewer or the respondent, and data entry errors. Although numerous efforts were made during the implementation of the 2014 Afghanistan Health and Nutrition baseline survey to minimize this type of error, nonsampling errors are impossible to avoid and difficult to evaluate statistically.

Sampling errors, on the other hand, can be evaluated statistically. The sample of respondents selected in the 2014 AHNS is only one of many samples that could have been selected from the same population, using the same design and expected size. Each of these samples would yield results that differ somewhat from the results of the actual sample selected. Sampling errors are a measure of the variability between all possible samples. Although the degree of variability is not known exactly, it can be estimated from the survey results.

Sampling error is usually measured in terms of the *standard error* for a particular statistic (mean, percentage, etc.), which is the square root of the variance. The standard error can be used to calculate confidence intervals within which the true value for the population can reasonably be assumed to fall. For example, for any given statistic calculated from a sample survey, the value of that statistic will fall within a range of plus or minus two times the standard error of that statistic in 95 percent of all possible samples of identical size and design.

If the sample of respondents had been selected as a simple random sample, it would have been possible to use straightforward formulas for calculating sampling errors. However, the 2014 AHNS sample is the result of a multi-stage stratified design, and, consequently, it was necessary to use more complex formulas. Sampling errors were computed using programs developed by ICF International. These programs use the Taylor linearization method of variance estimation for survey estimates that are means, proportions, or ratios. This method treats any percentage or average as a ratio estimate,  $r = y/x$ , where  $y$  represents the total sample value for variable  $y$ , and  $x$  represents the total number of cases in the group or subgroup under consideration.

The Jackknife repeated replication method is used for variance estimation of more complex statistics such as fertility and mortality rates. The Jackknife repeated replication method derives estimates of complex rates from each of several replications of the parent sample, and calculates standard errors for these estimates using simple formulas. Each replication considers *all but one* cluster in the calculation of the estimates. Pseudo-independent replications are thus created. In the 2014 AHNS, there were 40 non-empty clusters. Hence, 39 replications were created.

In addition to the standard error, the design effect (DEFT) for each estimate is also calculated. The design effect is defined as the ratio between the standard error using the given sample design and the standard error that would result if a simple random sample had been used. A DEFT value of 1.0 indicates that the sample design is as efficient as a simple random sample, while a value greater than 1.0 indicates the increase in the sampling error due to the use of a more complex and less statistically efficient design. Relative standard errors and confidence limits for the estimates are also calculated.

Sampling errors are calculated for selected variables considered to be of primary interest. The results are presented below for the sample as a whole. For each variable, the type of statistic (mean, proportion, or rate) and the base population are given in Table B.1. Table B.2 presents the value of the

statistic (R), its standard error (SE), the number of unweighted (N) and weighted (WN) cases, the design effect (DEFT), the relative standard error (SE/R), and the 95 percent confidence limits ( $R \pm 2SE$ ), for each variable. The DEFT is considered undefined when the standard error considering a simple random sample is zero (when the estimate is close to 0 or 1).

The confidence interval (e.g., as calculated for currently using any method) can be interpreted as follows: the overall average from the whole sample is 0.176 and its standard error is 0.016. Therefore, to obtain the 95 percent confidence limits, one adds and subtracts twice the standard error to the sample estimate, i.e.,  $0.176 \pm 2 \times 0.016$ . There is a high probability (95 percent) that the true average percentage of currently married women age 15-49 who are using any method is between 0.144 and 0.207.

For the total sample, the value of the DEFT, averaged over all 22 variables for which it can be calculated, is 1.66. This means that, due to multi-stage clustering of the sample, the average standard error is increased by a factor of 1.66 over that in an equivalent simple random sample.

**Table B.1 List of selected variables for sampling errors, Afghanistan 2014**

Variable	Estimate	Base population
Currently pregnant	Proportion	Ever-married women 15-49
Currently using any method	Proportion	Currently married women 15-49
Currently using a modern method	Proportion	Currently married women 15-49
Currently using a traditional method	Proportion	Currently married women 15-49
Used public sector source	Proportion	Current users of modern method
Want no more children	Proportion	Currently married women 15-49
Want to delay next birth at least 2 years	Proportion	Currently married women 15-49
Ideal number of children	Mean	Ever-married women 15-49
Mothers received antenatal care for last birth	Proportion	Women with a live birth in last five years
Births with skilled attendant at delivery	Proportion	Births occurring 1-59 months before survey
Had diarrhea in the past 2 weeks	Proportion	Children under 5
Received BCG vaccination	Proportion	Children 12-23 months
Received Pentavalent vaccination (3 doses)	Proportion	Children 12-23 months
Received polio vaccination (3 doses)	Proportion	Children 12-23 months
Received measles vaccination	Proportion	Children 12-23 months
Received all vaccinations	Proportion	Children 12-23 months
Total fertility rate (3 years)	Rate	Woman-years of exposure to childbearing
Neonatal mortality rate <sup>1</sup>	Rate	Children exposed to the risk of mortality
Post-neonatal mortality rate <sup>1</sup>	Rate	Children exposed to the risk of mortality
Infant mortality rate <sup>1</sup>	Rate	Children exposed to the risk of mortality
Child mortality rate <sup>1</sup>	Rate	Children exposed to the risk of mortality
Under-five mortality rate <sup>1</sup>	Rate	Children exposed to the risk of mortality

<sup>1</sup> The mortality rates are calculated for 5 years before the survey

**Table B.2 Sampling errors, Afghanistan 2014**

Variable	R	SE	N-UNWT	WN-WTD	DEFT	SE/R	R-2SE	R+2SE
Currently pregnant	0.101	0.013	1708	1471	0.862	0.133	0.074	0.127
Currently using any method	0.176	0.016	953	943	1.29	0.091	0.144	0.207
Currently using a modern method	0.174	0.016	953	943	1.288	0.091	0.143	0.206
Currently using a traditional method	0.001	0.001	953	943	1.081	1.03	0	0.004
Used public sector source	0.955	0.029	192	164	1.946	0.031	0.896	1.014
Want no more children	0.365	0.021	953	943	1.362	0.058	0.322	0.407
Want to delay birth at least 2 years	0.226	0.038	953	943	2.796	0.169	0.15	0.302
Ideal number of children	5.981	0.093	979	974	1.312	0.016	5.794	6.168
Mothers received antenatal care for last birth	0.455	0.063	664	673	3.25	0.138	0.33	0.58
Births with skilled attendant at delivery	0.453	0.045	1009	1024	2.292	0.099	0.364	0.543
Had diarrhea in the last 2 weeks	0.193	0.026	957	987	1.913	0.133	0.141	0.244
Received BCG vaccination	0.822	0.041	260	279	1.775	0.05	0.74	0.903
Received DPT vaccination (3 doses)	0.692	0.041	260	279	1.479	0.059	0.61	0.775
Received polio vaccination (3 doses)	0.731	0.032	260	279	1.206	0.044	0.666	0.795
Received measles vaccination	0.756	0.041	260	279	1.597	0.054	0.673	0.838
Received all vaccinations	0.667	0.044	260	279	1.547	0.066	0.579	0.754
Total fertility rate (last 3 years)	5.173	0.246	4302	4006	1.040	0.048	4.682	5.665
Neonatal mortality (last 0-4 years)	14.913	5.74	1034	1040	1.355	0.385	3.434	26.393
Post-neonatal mortality (last 0-4 years)	20.661	7.342	1037	1043	1.597	0.355	5.978	35.345
Infant mortality (last 0-4 years)	35.574	11.405	1037	1043	1.77	0.321	12.765	58.384
Child mortality (last 0-4 years)	8.751	3.245	1070	1099	1.145	0.371	2.261	15.241
Under-five mortality (last 0-4 years)	44.015	12.898	1044	1047	1.698	0.293	18.219	69.81

APPENDIX C

**SAMPLE IMPLEMENTATION**

Table C.1 Household age distribution

Single-year age distribution of the de facto household population by sex (weighted), Afghanistan

2014									
Age	Women				Age	Men			
	n		Me			n		Me	
	Number	Percent	Number	Percent		Number	Percent	Number	Percent
0	44	1.3	52	1.6	36	16	0.5	14	0.4
1	128	3.9	154	4.8	37	22	0.7	12	0.4
2	108	3.3	112	3.5	38	38	1.1	22	0.7
3	105	3.2	85	2.6	39	13	0.4	2	0.1
4	111	3.3	98	3.0	40	85	2.6	88	2.7
5	111	3.4	66	2.0	41	6	0.2	11	0.3
6	136	4.1	126	3.9	42	6	0.2	4	0.1
7	104	3.1	131	4.1	43	6	0.2	7	0.2
8	127	3.8	138	4.3	44	2	0.1	9	0.3
9	89	2.7	82	2.6	45	47	1.4	77	2.4
10	130	3.9	118	3.7	46	17	0.5	7	0.2
11	55	1.7	56	1.7	47	9	0.3	13	0.4
12	108	3.3	108	3.3	48	23	0.7	20	0.6
13	91	2.8	85	2.6	49	9	0.3	5	0.1
14	100	3.0	108	3.3	50	63	1.9	62	1.9
15	106	3.2	110	3.4	51	19	0.6	11	0.3
16	89	2.7	92	2.8	52	27	0.8	13	0.4
17	61	1.8	43	1.3	53	9	0.3	6	0.2
18	114	3.4	115	3.6	54	2	0.1	2	0.1
19	50	1.5	24	0.8	55	38	1.2	41	1.3
20	121	3.6	98	3.0	56	2	0.1	13	0.4
21	30	0.9	21	0.7	57	2	0.1	11	0.4
22	53	1.6	55	1.7	58	7	0.2	7	0.2
23	44	1.3	31	1.0	59	3	0.1	11	0.4
24	46	1.4	33	1.0	60	38	1.1	70	2.2
25	76	2.3	77	2.4	61	2	0.0	2	0.1
26	31	0.9	32	1.0	62	1	0.0	4	0.1
27	24	0.7	22	0.7	63	0	0.0	1	0.0
28	44	1.3	50	1.5	64	0	0.0	1	0.0
29	8	0.2	10	0.3	65	14	0.4	19	0.6
30	127	3.8	83	2.6	66	1	0.0	0	0.0
31	7	0.2	8	0.2	67	0	0.0	14	0.4
32	27	0.8	24	0.7	68	0	0.0	6	0.2
33	25	0.8	6	0.2	69	1	0.0	1	0.0
34	12	0.4	9	0.3	70+	46	1.4	91	2.8
35	96	2.9	91	2.8	DK/ missing	1	0.0	0	0.0
					Total	3,310	100.0	3,230	100.0

Note: The de facto population includes all residents and nonresidents who stayed in the household the night before the interview.

**Table C.2 Completeness of reporting**

Percentage of observations missing information for selected demographic and health questions (weighted), Afghanistan 2014

Subject	Reference group	Percentage with information missing	Number of cases
<b>Birth date</b>	Births in the 15 years preceding the survey		
Month only		0.00	3,119
Month and year		0.00	3,119
<b>Age at death</b>	Deceased children born in the 15 years preceding the survey	0.00	230
<b>Age/date at first union<sup>1</sup></b>	Ever-married women age 15-49	0.00	974
<b>Respondent's education</b>	Ever-married women age 15-49	0.00	974
<b>Diarrhea in past 2 weeks</b>	Living children age 0-59 months	1.12	987

<sup>1</sup> Both year and age missing

**Table C.4 Births by calendar years**

Number of births, percentage with complete birth date, sex ratio at birth, and calendar year ratio by calendar year, according to living (L), dead (D), and total (T) children (weighted), Afghanistan 2014

Calendar year	Number of births			Percentage with complete birth date <sup>1</sup>			Sex ratio at birth <sup>2</sup>			Calendar year ratio <sup>3</sup>		
	L	D	T	L	D	T	L	D	T	L	D	T
2014	95	2	97	100.0	100.0	100.0	125.7	197.0	126.7	na	na	na
2013	275	7	283	100.0	100.0	100.0	116.3	186.7	117.6	na	na	na
2012	219	8	228	100.0	100.0	100.0	119.6	443.9	124.5	94.9	95.4	95.0
2011	186	10	197	100.0	100.0	100.0	78.1	358.7	84.0	88.2	119.4	89.4
2010	204	9	213	100.0	100.0	100.0	81.6	242.7	85.3	111.3	102.1	110.9
2009	180	7	187	100.0	100.0	100.0	58.3	115.8	60.0	79.7	47.0	77.6
2008	247	22	269	100.0	100.0	100.0	92.2	224.8	99.0	121.9	234.6	127.0
2007	225	12	237	100.0	100.0	100.0	127.0	207.4	130.0	90.4	62.2	88.4
2006	252	15	267	100.0	100.0	100.0	100.8	258.4	105.9	130.9	66.1	123.9
2005	160	34	194	100.0	100.0	100.0	91.7	183.2	103.3	67.3	251.8	77.3
2010-2014	980	37	1,017	100.0	100.0	100.0	101.5	285.2	105.1	na	na	na
2005-2009	1,063	91	1,154	100.0	100.0	100.0	93.4	198.5	98.9	na	na	na
2000-2004	843	101	943	100.0	100.0	100.0	96.4	158.9	101.6	na	na	na
1995-1999	590	68	658	100.0	100.0	100.0	83.7	225.1	92.3	na	na	na
< 1995	410	92	502	100.0	100.0	100.0	140.2	121.4	136.6	na	na	na
All	3,885	388	4,273	100.0	100.0	100.0	98.6	174.8	103.7	na	na	na

na = Not applicable

<sup>1</sup> Both year and month of birth given

<sup>2</sup> (Bm/Bf)x100, where Bm and Bf are the numbers of male and female births, respectively

<sup>3</sup> [2Bx/(Bx-1+Bx+1)]x100, where Bx is the number of births in calendar year x

**Table C.5 Reporting of age at death in days**

Distribution of reported deaths under one month of age by age at death in days and the percentage of neonatal deaths reported to occur at ages 0-6 days, for five-year periods of birth preceding the survey (weighted), Afghanistan 2014

Age at death (days)	Number of years preceding the survey				Total 0-19
	0-4	5-9	10-14	15-19	
<1	0	1	0	0	1
1	4	9	5	10	28
2	1	4	0	3	9
3	1	8	1	2	13
4	0	0	4	3	8
5	0	0	1	0	2
6	2	3	0	1	5
7	1	0	0	0	1
8	0	0	0	0	0
9	1	0	0	0	1
10	2	0	7	3	12
11	0	2	1	0	3
12	1	1	0	0	2
13	2	0	0	0	2
15	1	0	0	2	2
16	0	0	0	1	1
18	0	0	1	0	1
20	0	9	1	2	11
21	0	0	0	1	1
24	0	0	0	0	0
30	0	12	0	2	13
Total 0-30	16	49	21	30	116
Percentage early neonatal <sup>1</sup>	57.8	50.1	58.7	65.6	56.7

<sup>1</sup> 0-6 days / 0-30 days

**Table C.6 Reporting of age at death in months**

Distribution of reported deaths under two years of age by age at death in months and the percentage of infant deaths reported to occur at age under one month, for five-year periods of birth preceding the survey, Afghanistan 2014

Age at death (months)	Number of years preceding the survey				Total 0-19
	0-4	5-9	10-14	15-19	
<1	16	49	21	30	116
1	2	0	9	12	23
2	1	3	10	2	17
3	2	5	14	2	23
4	2	5	11	1	19
5	5	8	6	1	19
6	0	5	9	3	18
7	1	0	2	4	7
8	3	0	0	0	4
9	1	1	2	3	8
10	0	0	0	0	0
11	1	0	0	1	1
20	0	0	0	0	0
1 Year	2	6	11	4	23
Total 0-11	35	78	84	59	255
Percentage neonatal <sup>1</sup>	44.9	62.8	25.3	51.1	45.3

<sup>a</sup> Includes deaths under one month reported in days

<sup>1</sup> Under one month / under one year

