Formative Assessment of Knowledge, Attitudes, and Preferred Media for Reproductive Health Engagement among Selected Groups of Youth and Men in Afghanistan

HEMAYAT Project

December 7, 2018

TABLE OF CONTENTS

Acknowledgments i

Acronyms and Abbreviations ii

Letter from the Ministry of Public Health 1

Executive Summary 2

1. BACKGROUND AND RATIONALE 7

Purpose 8

Objectives 8

2. METHODS 8

Study Sites and Population 9

Personnel 10

Instrument Development 10

Recruitment and Data Collection 11

Sample Size Justification 14

Data Analysis 15

Ethics Review 16

3. QUANTITATIVE RESULTS 16

Youth 16

Men 63

4. QUALITATIVE RESULTS 99

Health Care Access 105

Communication Platforms for Health Messaging 109

5. DISCUSSION 115

FP/RMNCH Knowledge Deficiencies, Perceived Gaps, and Inaccuracies among Audience Segments 116

Gender and Social Norms Around Marriage, FP/RMNCH Information and Access to Care, and Impact on Care Utilization 118

FP/RMNCH Information Channel Preferences and Mismatches between Preference and Engagement 122

Suboptimal FP/RMNCH Content, Channel Coverage, and Comprehensive Engagement of Target Audiences and Key Influencers 124

Perceived Feasibility, Barriers to Use, and Desired Features for Mobile Phone RMNCH Interventions 126

Limitations 126

6. RECOMMENDATIONS AND CONCLUSIONS 128

Message Content and Channel Modifications 129

Addressing Gender Norms in Content to Increase Male Inclusion and Female Agency 129

Improving FP/MNCH Service Demand through Access and Quality 131

Preferred Mass Media Channels and Optimizing FP/RMNCH Programming for Media 132

Optimizing mobile phone potential as a health communications channel 133

Special Population Considerations 134

Conclusions 135

REFERENCES 136

List of Tables

Table 2.1. Sites and sample sizes for participant groups among men and youth in Afghanistan

Table 2.2. Inclusion criteria for in-depth interview participants (n=49)

Table 2.3. Inclusion criteria for focus group discussion participants (n=67)

Table 2.4. Quantitative analysis approach for key outcome measures

Table 3.1. Sociodemographic characteristics among IDP youth from three provinces (Kandahar, Nangarhar, and Takhar), by sex and marital status (Afghanistan, 2017) (n=452)

Table 3.2. Media exposure among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Table 3.3. Television and radio programming preferences among IDP youth reporting media exposure in the past month, by sex and marital status (Afghanistan, 2017) (n=207)

Table 3.4. Health topics reported among IDP youth exposed to health messages broadcast on radio and television in the past month, by sex and marital status (Afghanistan, 2017) (n=89 for radio and n=73 for television)

Table 3.5. Mobile phone ownership among IDP youth, segmented by sex and marital status and disaggregated by various factors (Afghanistan, 2017) (n=451)

Table 3.6. Counseling topics provided by health care providers to IDP youth receiving health counseling in the past six months, by sex and marital status (Afghanistan, 2017) (n=182)

Table 3.7. Knowledge of antenatal care, pregnancy complications, and risks among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Table 3.8. Knowledge of intrapartum care and complications among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Table 3.9. Knowledge of newborn care, including appropriate cord care, newborn temperature regulation, and initiation of breastfeeding among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Table 3.10. Correlates of knowledge of chlorhexidine use for umbilical cord care among IDP youth, by sex and marital status (Afghanistan, 2017) (n=447)

Table 3.11. Knowledge of early breastfeeding initiation among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Table 3.12. Agreement with family planning statements among married IDP youth (Afghanistan, 2017) (n=207)

Table 3.13. Associations between key variables and health care-seeking behavior in the past three months among IDP youth (Afghanistan, 2017) (n=451)

Table 3.14. Level of agreement or uncertainty regarding gender equity and norms within marriage among IDP youth, by sex and marital status. (Afghanistan 2017) (number variable; proportion disagreeing or declining to respond not shown)

Table 3.15. Levels of agreement with statements about marriage among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Table 3.16. Perceived social norms concerning maternal, newborn, and child health and family planning among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Table 3.17. Media exposure among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Table 3.18. Preferences for radio and television program content among school-based youth reporting any media exposure, by sex (Afghanistan, 2017) (n=667 for radio and 853 for television)

Table 3.19. Sociobehavioral characteristics associated with mobile phone ownership among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Table 3.20. Health counseling topics discussed with a health care provider in the last six months among school-based youth, by sex (Afghanistan, 2017) (n=595)

Table 3.21. Knowledge of antenatal care, pregnancy complications, and labor/delivery risks among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Table 3.22. Knowledge of newborn care, including appropriate cord care, newborn temperature regulation, and initiation of breastfeeding among school-based youth, by sex (Afghanistan, 2017) (n=1200)

Table 3.23. Correlates of knowledge of chlorhexidine use for umbilical cord care among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Table 3.24. Factors independently associated with knowledge of correct timing of breastfeeding initiation among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Table 3.25. Factors associated with knowledge of correct LAM duration in bivariate analysis among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Table 3.26. Agreement with family planning statements among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Table 3.27. Factors associated with selected correct family planning knowledge statements among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Table 3.28. Associations between key variables and health care-seeking behavior in the past three months among school-based youth, by sex (Afghanistan, 2017) (n=1200)

Table 3.29. Perceived social norms and attitudes regarding marriage timing and spousal selection, among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Table 3.30. Attitudes regarding perceived gender equity and norms within marriage among school-based youth, by sex (Afghanistan, 2017) (n=1,200)†

Table 3.31. Perceived social norms concerning maternal, newborn, and child health and family planning among school-based youth, by sex (Afghanistan, 2017) (n=1200)

Table 3.32. Sociodemographic characteristics among men from seven provinces (Balkh, Bamiyan, Herat, Kabul, Kandahar, Nangarhar, and Takhar), by IDP and marital status (Afghanistan, 2017) (n=1,658)

Table 3.33. Literacy level by years of education among men reporting up to six years of formal education (Afghanistan, 2017) (n=291)

Table 3.34. Media exposure among men, by IDP and marital status (Afghanistan, 2017) (n=1,658)

Table 3.35. Counseling topics received by men who sought health care services from a provider in the past six months, by IDP and marital status (Afghanistan, 2017) (n=549)

Table 3.36. Sources of information about delaying marriage, child health, and family planning among men who received messages about these topics in the past 12 months, by IDP and marital status (Afghanistan, 2017) (n= 485-632; top three sources in bold type)

Table 3.37. Knowledge of antenatal care, pregnancy complications, and labor/delivery risks among men, by marital and IDP status (Afghanistan, 2017) (n=1,658)

Table 3.38. Correlates of preferring facility-based delivery among adult male respondents, by marital and IDP status (Afghanistan, 2017) (n=1496)

Table 3.39. Knowledge of newborn care, including appropriate cord care, newborn temperature regulation, and initiation of breastfeeding among men, by marital and IDP status (Afghanistan, 2017) (n=1,200)

Table 3.40. Correlates of knowledge of chlorhexidine use for umbilical cord care among adult male respondents, by marital and IDP status (Afghanistan, 2017) (n=1,650)

Table 3.41. Associations between awareness of specific family planning methods and key sociodemographic characteristics among men, by marital and IDP status (Afghanistan, 2017) (n=1,090)†

Table 3.42. Family planning perceptions and misconceptions among men, by marital and IDP status (Afghanistan, 2017) (n=1,658) (correct response in bold)

Table 3.43. Associations between sociodemographic characteristics and correct knowledge of family planning among men (Afghanistan, 2017) (n=1658)

Table 3.44. Level of agreement or uncertainty regarding gender equity and norms within marriage among men, by marital and IDP status (Afghanistan, 2017) (number variable; proportion disagreeing or declining to respond not shown)

Table 3.45. Perceived social norms concerning maternal, newborn, and child health and family planning among men, by marital and IDP status (Afghanistan, 2017) (n=1,658)

Table 3.46. Correlates of agreement with perceptions surrounding FP/MNCH care access and community social norms that lacked consensus among segmented populations of adult men (Afghanistan, 2017) (n=1,658)

Table 3.47. Reported household decision-making authority among married men (Afghanistan, 2017) (n=1,128)

Table 3.48. Factors significantly associated with reported joint household decision making among married men (Afghanistan, 2017) (n=1,127)

Table 3.49. Contraceptive method mix and factors associated with specific method use among couples, reported by married men reporting current family planning use (Afghanistan, 2017) (n=430)

List of Figures

Figure 1.1 Study provincial coverage and target population

Figure 3.1. Household wealth indicators among IDP youth (Afghanistan, 2017) (n=451)

Figure 3.2 Highest education level attained among IDP youth, by sex (Afghanistan, 2017) (n=451)

Figure 3.3. Most frequent radio and television viewing times among male and female IDP youth (Afghanistan, 2017) (n=207 for radio and 133 for television)

Figure 3.4. Most frequent radio and television viewing times among male and female IDP youth (Afghanistan, 2017) (n=207 for radio and 133 for television)

Figure 3.5. Most convenient and most accurate health information sources for delaying marriage among unmarried IDP youth receiving counseling for marriage delay, by sex (Afghanistan, 2017 (n=51)

Figure 3.6. Most convenient and most accurate sources for child health information among IDP youth receiving counseling on child health, by sex and marital status (Afghanistan, 2017) (n=157)

Figure 3.7. Most convenient and most accurate family planning information among married IDP youth receiving health counseling, by sex (Afghanistan, 2017) (n=75)

Figure 3.8. Knowledge of exclusive breastfeeding duration (in months) among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Figure 3.9. Knowledge of complementary breastfeeding duration (in months) among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Figure 3.10. Awareness of family planning methods among married IDP youth, by sex (Afghanistan, 2017) (n=123)

Figure 3.11. Likelihood of using a free mobile phone-based service for health advice among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Figure 3.12. Household wealth indicators among school-based youth (Afghanistan, 2017) (n=1,200)

Figure 3.13. Highest education level attained by school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Figure 3.14. Most frequent radio and television viewing times among school-based youth, by sex (Afghanistan, 2017) (n=667 for radio and 853 for television)

Figure 3.15. Health topics received among school-based youth reporting exposure to health messages from media within the past month, by sex and media source (Afghanistan, 2017) (n=255 for print media, 362 for radio, and 537 for television)

Figure 3.16. Most convenient and most accurate health information sources reported by school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Figure 3.17. Knowledge of exclusive breastfeeding duration (in months) among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Figure 3.18. Knowledge of peak fertility among school-based youth, by sex (Afghanistan, 2017) (n=584)

Figure 3.19. Awareness of family planning methods among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Figure 3.20. Likelihood of school-based youth using a free mobile phone-based service for health advice, by sex (Afghanistan, 2017) (n=1200)

Figure 3.21. Household wealth indicators among adult male respondents (Afghanistan, 2017) (n=1,658)

Figure 3.22. Most frequent radio and television viewing times reported by men, by IDP status (Afghanistan, 2017) (n=716 for radio and n=906 for television)

Figure 3.23. Information sources for selected topics perceived most accurate and most convenient among men, by marital status (Afghanistan, 2017) (n=485 - 632)

Figure 3.24. Information sources for selected topics perceived most accurate and most convenient among men, by IDP status (Afghanistan, 2017) (n= 485 - 632)

Figure 3.25. Actions families can take to reduce health risks during pregnancy according to adult male respondents (Afghanistan, 2017) (n=1570)

Figure 3.26. Knowledge of exclusive breastfeeding duration among married men (Afghanistan, 2017) (n=1,126)

Figure 3.27. Knowledge of exclusive breastfeeding duration among IDP men (Afghanistan, 2017) (n=450)

Figure 3.28. Knowledge of peak fertility among married and IDP men (Afghanistan, 2017) (n=545)

Figure 3.29. Usual sources of health information among men (Afghanistan, 2017) (n=1638)

Acknowledgments

A team from the U.S. Agency for International Development (USAID)-funded Helping Mothers and Children Thrive in Afghanistan (HEMAYAT) project—in collaboration with Assess, Transform, and Reach (ATR) Consulting and the Health Promotions Department and Evaluation and Health Information Systems Directorate of the Ministry of Public Health (MOPH) of the Islamic Republic of Afghanistan—conducted this formative assessment of knowledge, attitudes, and preferred media regarding messaging for reproductive health (RH) information among youth and men in Afghanistan.

Our team is grateful to the many people who contributed to this study. Experts from international and national nongovernmental organizations, the MOPH technical units, and USAID participated in planning the survey and were instrumental in its success. Professionals from the MOPH and from the HEMAYAT project in Kabul were involved in all aspects of planning, implementation, and dissemination. We particularly acknowledge colleagues in the Health Promotions Department of the MOPH for their active participation and leadership. ATR Consulting supported the team in sampling and data collection for this survey.

We thank our participants and, where relevant, their families for the time it took to participate in this survey. Special acknowledgement goes to the men and women of Afghanistan who collected data in difficult conditions and to our monitors, study coordinators, and field managers who aided in data quality control and management. The data collection and monitoring teams completed a substantial task with great effort to ensure quality in an often-challenging security context. We also appreciate the time from those who reviewed and edited this report, as well as the operations, contracts, and finance departments that ensured the success of this study through their support.

Acronyms and Abbreviations

AFS	Afghanis (national currency; 67 Afghanis=US$1)
ANA	Afghanistan National Army
ANC	antenatal care
ANSF	Afghanistan National Security Forces
AOR	adjusted odds ratio
ATR	Assess, Transform, & Reach Consulting
CI	confidence interval
CHW	community health worker
CHX	chlorhexidine
FHA	Family Health Action
FGD	focus group discussion
FP	family planning
GIHS	Ghazanfar Institute of Health Sciences
HEMAYAT	Helping Mothers & Children Thrive in Afghanistan
HII	high-impact intervention
HPD	Health Promotions Department
IDI	in-depth interview
IDP	internally displaced person
IPV	intimate partner violence
IQR	interquartile range
IUCD	intrauterine contraceptive device
IVR	interactive voice response
LAM	lactational amenorrhea method
MNCH	maternal, newborn, and child health
MOPH	Ministry of Public Health
N	number
OR	odds ratio
PNC	postnatal care
RH	reproductive health
RMNCH	reproductive, maternal, newborn, and child health
SBC	social and behavioral change
SD	standard deviation
TFR	total fertility rate
USAID	U.S. Agency for International Development

Letter from the Ministry of Public Health

Foreword

The Formative Assessment of Knowledge, Attitudes, and Preferred Media for Reproductive Health Engagement among Selected Groups of Youth and Men in Afghanistan is among the first formative studies of critical target populations, men and young people, for health promotion in Afghanistan. The study was implemented by a joint effort between the Ministry of Public Health, the United States Agency for International Development (USAID)-funded Helping Mothers and Children Thrive in Afghanistan (HEMAYAT) project, and Assess, Transform, and Reach consulting. The aim of the study was to inform reproductive health, maternal, newborn, and child health demand-generation programming targeting youth and men, and to improve maternal and child health outcomes through sustained behavior change. Accordingly, we hope the information contained in this report will assist policy makers and program staff in designing, implementing, modifying and monitoring strategies and activities that better incorporate youth and men towards achieving the larger goal of improved family health in Afghanistan.

This formative assessment is a cross-sectional survey including data from seven provinces from a diverse set of adult male and youth groups, including internally-displaced populations. While not a representative sample, the study provides important data regarding media exposure and use; levels of reproductive, maternal, newborn, and child health knowledge and attitudes; social and gender norms surrounding marital and health decision-making and care-seeking; and preferred health information sources.

The success of this study was made possible by a number of organizations and groups. We appreciate the support of the USAID in Afghanistan for funding the study. We also extend our gratitude for the valuable technical input provided by the Health Promotions and the Reproductive Health Technical Working Groups during the different phases of the survey; critical inputs from these groups contributed to successful study design and results synthesis. Further, the support and collaboration from the national and provincial administration, nongovernmental development organizations, and other key stakeholders is acknowledged with thanks.

Sincerely,
Dr. Shafiqullah Hemat
Manager, Health Promotions Department

EXECUTIVE SUMMARY

Study Rationale/Purpose

In Afghanistan, many of the improvements in maternal, newborn, and child health (MNCH) are attributed to improved health and health-seeking behaviors and increased access to medical services. To continue this trajectory, it is essential to understand norms and perceptions among critical target populations regarding best practices for family planning (FP) and reproductive and MNCH (RMNCH) and to generate demand for FP/MNCH commodities and services. Most current social and behavior change (SBC) programming focuses on women of childbearing age; however, these approaches overlook the importance of adult men as the primary household health decision makers, and of male and female youth as future health consumers. To reach these groups, who play important roles in current and future use of health services, it is essential to understand their current experience with FP/RMNCH messaging and other content; associated FP/RMNCH knowledge, attitudes, and practice; broader gender and social norms around FP/RMNCH; and preferences with regard to content and channels for future SBC programming. Further, a segmented approach is needed to address diverse groups within these broader populations, particularly segmenting by internal displacement, sex, and marital status.

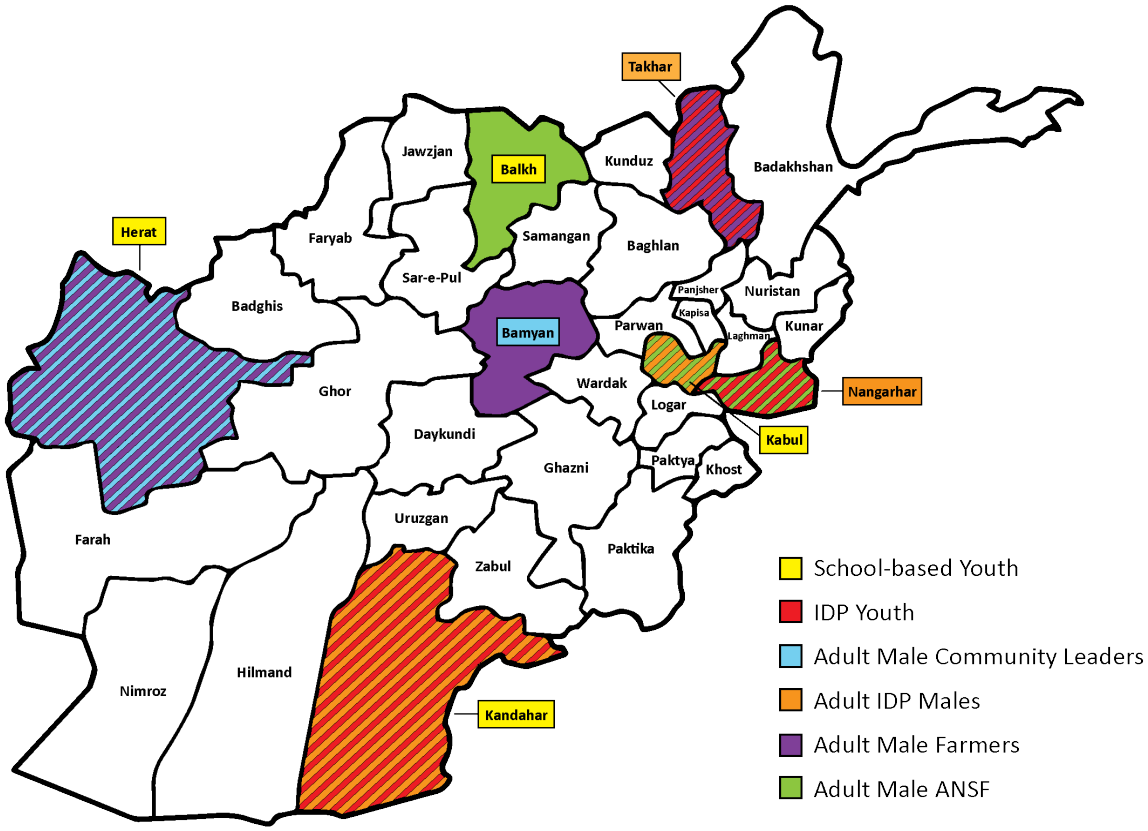
The goal of our formative study was to inform FP/RMNCH demand-generation programming targeting youth and men, and to improve maternal and child health outcomes through sustained behavior change. The cross-sectional, mixed methods study provided formative information to guide selection of FP/RMNCH-related SBC topics and content, to identify priority communications channels, and to tailor interventions for specific target audiences segmented by educational status and region.

Methods

Our study team, representing a collaboration between the U.S. Agency for International Development (USAID)-funded Helping Mothers & Children Thrive in Afghanistan (HEMAYAT) project, ATR Consulting, and the Ministry of Public Health (MOPH), interviewed 1,658 adult men and 1,200 school-based and 452 internally displaced youth ages 15–25 years across seven provinces in urban and rural locations of Afghanistan between March and July 2017. Female and male youth were enrolled in equal numbers by sex-matched interviewers (i.e., men interviewed men and women interviewed women). All quantitative surveyors were recruited from the provinces where they conducted interviews, while male and female staff trained in qualitative data collection covered multiple provinces. FHI 360, within the HEMAYAT consortium, conducted the data analysis and synthesis for this convenience sample.

In quantitative interviews, we measured socioeconomic characteristics; media use and health information exposure; preferences for health information sources and for messaging content and channels; FP/RMNCH knowledge, norms, and attitudes; mobile phone ownership and use; and preferences around mobile phone-based programming. In qualitative interviews, we explored FP/RMNCH message exposure and content and channel preferences; barriers to accessing health information, programming, and care; and interest in and access to mobile phones for health messaging. We analyzed quantitative data descriptively and segmented the analysis by key demographic factors, including sex and marital status for youth, and marital and internally displaced person (IDP) status for adult men. Within segmented groups, we analyzed important program preferences, such as mobile phone-based messaging, and factors relevant to SBC, such as gender norms, with tests of association to determine relationships for guiding programming decisions. We analyzed qualitative data using an open-coding approach to explore the context around media and health care access and to obtain insights into potential facilitators and the navigation of barriers surrounding mobile phone-based SBC programming.

Figure 1.1: Study provincial coverage and target population



Results and Recommendations

We present the following main findings and associated recommendations applicable to all surveyed populations:

Finding: ***Messages are not tailored to audiences and are not action-oriented.*** Currently, most messages relayed through mass media and community-based channels (e.g. CHWs) are the same for all audiences and generally don't include action-based content (e.g. the warning signs of pregnancy and what to do if these signs are present) or adaptation of messages to specific target audiences based on social norms and their role in health decision-making. Our data point to adult men stating they take actions based on their perception of what is needed, such as purchasing a baby's clothes. This reflects a willingness to act that could be re-directed through statements establishing rationale for and then specifying the necessary action.

> ***Recommendation:*** ***FP/RMNCH information should include sufficient reasons for inciting behavior change but also needs to be brief and easily understood by most target populations.*** Messages that spell out specific actions for optimal FP/RMNCH outcomes should be developed and pre-tested with focus groups of each target audience in several geographically and ethnically diverse settings. Breadth of pre-testing will ensure wording is correct, determine the best channel for dissemination, and confirm that assumed decision-making roles ascribed to men are culturally congruent.

Finding: ***Health care providers and teachers were the most trusted source for FP/RMNCH information but misconceptions were common and widely held.***

Recommendation: ***Future FP/RMNCH SBC programming should address widely-held misconceptions through credible sources in creative ways.*** Referencing the MOPH or an esteemed health professions school as the source of information or having the message delivered by prominent health providers, would be an ideal channel to correct knowledge misconceptions, particularly those surrounding FP and infant care and nutrition. For youth audiences, incorporating messages that counter misconceptions within songs, games, or school-based programming should be tested for feasibility and impact on knowledge and behavior. Multiple formats for messages and channels will likely be necessary to ensure the broadest reach and appeal to youth due to different norms for educational attainment and media access by sex, urban versus rural residence, and regional differences.

Finding: ***Some positive gender norms could be incorporated in SBC programming to improve FP/RMNCH.*** Our data confirmed some traditional norms endorsed by a majority of both male and female youth, such as marriage being best before age 24 years for women. However, we also detected several positive trends that depart from traditional norms, such as nearly two-thirds of married men stating that they make major household decisions in collaboration with their wife. These differences could be incorporated into SBC programming and address critical social norms around decision-making and agency between married couples.

Recommendation: ***Build on positive norms and practices.*** Modify message content and channels to address and, ideally, transform widely-held gender and social norms that serve as barriers to improved FP/RMNCH. We recommend that these programs start with topics that are equally engaging for and seen more widely as the joint responsibility of both spouses, such as child nutrition and preparing for birth, and then transitioning to topics perceived to be gendered, such as responsibility for and selection of FP methods and breastfeeding practices. Current gender norms also include addressing hierarchical decision-making within households within each gender, and so should specifically focus on mothers-in-law as a target group given their influence over household health practices and ability to influence their son's decisions regarding health care for his wife.

Finding: ***Social norms for youth appear somewhat more flexible.*** Based on data suggesting changing norms around ideal age for and agency in marriage-decision making, young women and men appear to have different norms and expectations than their parents. Youth also frequently mention having family members as health information sources, reflecting need for accurate information to reach those sources. Educated youth report being a frequent information source within their families due to their literacy and potential ability to access appropriate reference materials and enable them to serve as a conduit to effect norm change among traditional key influencers within their households.

Recommendation: ***Separate SBC packages are needed for youth and key influencers.*** Addressing social norms around youth agency, particularly around timing of marriage and increasing decision-making autonomy for married youth, is needed. Discussion of these social norms could be united into a SBC package for "marriage preparation" for engaged youth or "parenthood preparation" for young married couples. While the content for the packages would be similar for primary male and female audiences, a separate package will be needed for critical secondary audiences, particularly parents of the couples as well as community and religious leaders to explain the benefits of understanding of RMNCH as part of marriage preparation and to seek advocacy and support for couples to execute their decisions around FP/RMNCH goals and care. Programming of this nature, which engages and informs young women and is endorsed by key influencers in the community, can transform how they are perceived in the household by mothers-in-law and/or husbands and thus elevate their agency and reduce the risk of intimate partner violence (IPV). This transformation may also lead to enhanced engagement and efficacy in ensuring that women receive respectful care at facilities. For young men, this type of package can re-set social norms around age being a pre-requisite for expertise and agency, and can provide more autonomy for marital and health decision making as well as re-set existing gender norms for men accessing health care for themselves.

Finding: ***There is a disconnect between desired and trusted SBC channels and access to those channels.*** Although health care providers were among the most trusted sources for FP/RMNCH information for all groups, there are numerous barriers to accessing a provider for information and care. In addition to described gender and social barriers, insufficient number of facilities and poor quality of care from providers were noted additional barriers to accessing care. Another key barrier to care was perceived lack of facilities with competent or female care providers within a reasonable distance, necessitating travel to district or provincial centers. Participants frequently mentioned negative interactions with different health facility personnel, either at a personal level or by someone within their community, as reasons for not seeking care or for traveling to distant facilities.

Recommendation: ***Demand generation for service use is critical and relies on engaging providers to improve quality of care and developing innovative approaches to expanding access.*** Health care providers and students at health professions schools are an important target audience for SBC, both for providing and updating necessary information and for improving norms around respectful care. SBC for providers can include testimonials from peers linking improved service quality to increased performance-based financing (PBF) reimbursements or fee for service, and can update critical knowledge and skills for professional development. A novel solution to increasing access to female providers include public-private approaches, such as Family Health Houses or Khana Qabila models, which are in pilot or early scale-up phases but may not be widely known outside their immediate communities. These ventures are staffed by midwives and represent a viable care option that may benefit from greater advertisement, particularly for facilities meeting a pre-determined competence level.

Finding: ***Mass media channels are key health information sources and many participants stated that visual media were preferred to confirm source credibility.*** Television is an important channel and access appears to be slowly increasing, making this channel a reasonable option for reaching urban and peri-urban citizens. Youth participants, particularly female youth, were more likely to watch television, and program and messaging styles should reflect their preferences for viewing time and style (e.g. preference for dramas over game shows). Radio appears to be less popular but is more widely accessible, particularly in rural areas, and largely used by adult men.

Recommendations: ***Developing media content with greater end-user input is critical for reaching youth and public-private models should be considered to expand SBC reach in a growing telecommunications market.*** For both program content and promotional materials, involving target audiences in development and pre-testing among key segments of audiences will increase the likelihood of exposure and engagement, particularly if there is an accompanying health provider or teacher discussion guide. Programming that includes a medical provider as part of the messaging, either as the principle speaker in a brief public service announcement or as the last speaker who summarizes key points after “edu-tainment” (e.g. a call-in game show or dramatization), can leverage this preferred information channel in a medium accessible to a large audience. Creative solutions may include developing a public-private venture as part of a telecommunication company’s corporate social responsibility program or enlisting advertising sponsors to defray air time costs to enable the MoPH and partners to have sustained access to SBC channels. Radio programming should consider peak audience listening times and having call-in shows with recognized celebrities or authorities assisting with discussion topics that engage collaborative solutions to barriers to FP/MNCH care.

Finding: ***Mobile phone-based programming represents a promising channel for RMNCH engagement, but there is low awareness and use of current programming as well as barriers to phone access for female youth and adult women.*** Current mobile phone-based health programs have not been widely promoted, even among subscribers of the mobile network operators that sponsor current programs. Most participants preferred “live” operator services; among mobile network operators, MTN has a sponsored service, as does MOPH in the public sector. However, few participants mentioned prior mobile

phone health program use, and the public sector call-in center was not spontaneously mentioned in any qualitative interviews. Cost also limits access as current mHealth services are available only through user-paid calls and require ongoing operational expenses for staffing and technology costs, especially for bidirectional models; the MoPH-operated call-in center has been suspended because of a funding lapse and other issues.

Recommendations: ***Mobile-based programming should be promoted to target audiences and key influencers, available on demand (a "pull" system), and involve two-way communication.*** Mobile phone programming that allows clients to access messaging on demand and at their convenience, rather than "blast" messaging, and programs that allow clients to speak to a live operator are likely to be better received. Advance marketing and directed promotions will be necessary for mobile phone SBC programming to reach target audiences for several reasons. First, marketing strategies for mobile-based client-controlled FP/RMNCH activities should be directed at male heads of household, community leaders, and other key influencers, to permit female and youth access to the number or short code associated with the program. This approach was recommended by both female and male youth and by adult men to address family concerns associated with unknown numbers and to reinforce the credibility of the information source. Next, greater promotion of mobile services is needed and multichannel promotion is likely to be most successful, combining digital "blast" promotion with radio or television advertisement and community-level promotion. Multichannel efforts (digital blast promotion, radio spots aired through regional stations, and promotion by health providers) resulted in 25,460 callers listening to complete FP messages on the Roshan 2-3-4 network in June, 2018. Last, mobile phone-based FP/RMNCH programming needs to consider public-private partnership approaches with MOPH or become an entirely private venture with MOPH oversight for content accuracy to ensure sustainability. As mobile technology for health interventions becomes more robust in Afghanistan, research is needed to better define the awareness, factors influencing use, and acceptable price points for both pre-recorded menu-based and live operator health services. Tailored FP/RMNCH mobile-based services for specific audiences, particularly basic RH and family health management information for youth in preparation for marriage, would likely be well-received if marketed widely and in a culturally-appropriate manner.

Conclusion

Overall, the key recommendation from this report is the need for comprehensive programming that merges detailed FP/RMNCH information with approaches that address and transform attitudes and normative perceptions to those that promote efficacy to improve health practices. The assessment findings also show that all target populations want interaction around sensitive and important topics, and provides insight into channels that can conceivably convey this information in a reliable, private, and cost-effective manner in the Afghan context. Looking forward, if activities that incorporate these recommendations are implemented, then developing indicators that assess FP/RMNCH information sources and exposure to community-level, mass media, and mobile-based interventions will be critical to refining these activities and determining levels of associated behavior change.

1. BACKGROUND AND RATIONALE

Afghanistan faces many health challenges, including high rates of maternal and child mortality.[1-3] Rates of skilled birth attendance at delivery and other key maternal, newborn, and child health (MNCH) care indicators have improved in the past decade.[2,3] However, maternal mortality ratios continue to be high, particularly around the time of childbirth and the immediate postpartum period.[3-5] Multiple barriers to antenatal care (ANC) and skilled care at delivery have been identified, but interventions to improve supply-side factors have had limited impact.[4,6] One key contributor is the high total fertility rate (TFR), currently at 5.3.[3] Contraceptive prevalence rates have stagnated over the past decade, with use of modern methods among reproductive-age women ranging from 18 to 23 percent in national household surveys.[3,5,7] Survey results are also notable for early age at marriage and childbearing, particularly for women, among whom the median age at first marriage is 18.5 years.[3] Newborn and child health statistics have also improved, but child immunization and nutrition indicators lag behind those of other countries in the region and vary markedly between provinces and between urban and rural settings.[3,8-10] Common and preventable childhood illnesses, particularly respiratory infection and diarrheal illness, contribute substantially to child mortality rates, while low birth weight and infection result in most cases of neonatal mortality.[3,9,10] These statistics have been relatively consistent for the last decade, during which demand-side interventions, such as health promotion to motivate facility-based reproductive and MNCH (RMNCH) care and family planning (FP) use, have been implemented through a variety of channels, approaches, and media sources.

Measuring the impact of health promotion and demand-generation activities is difficult, as many factors contribute to health behavior change and decisions surrounding access to care. Additionally, as the media market and access to information and communications technology have evolved rapidly in Afghanistan in recent years, changes in media coverage and preferences over time, and changes in international and national standards of care, may necessitate revised approaches to demand generation, including new channels and topics. One example of an area needing a revised approach for demand generation is the very limited involvement to date of the private sector in public health promotion, despite higher rates of health provider utilization in the private sector than in the public sector in a 2010 assessment.[11] In another example, mobile phone coverage is increasing within Afghanistan, both by number of users and by use among target populations, including women and youth.[12,13] However, while mobile phone-based health messaging and call-in centers have been sponsored through both public (e.g., MOPH) and private (e.g., the mobile network operator MTN) sectors, there has been little assessment of either exposure or impact through this media source in Afghanistan.

One key consideration for demand-generation activities for reproductive health (RH) is that most health promotion has been designed for married women of reproductive age, predominantly mothers of young children. Health decisions within a household, however, are typically made by the husband (alone or in collaboration with his spouse) or by an elder parent, rather than by the wife.[3,14-17] Existing demand-generation programming does not consider how to approach or change norms around collaborative decision making about health care. Further, very few campaigns specifically target men, and information is scarce regarding men's knowledge and attitudes about FP/MNCH access and use by their immediate families. Reports on health programming targeting men in Afghanistan are largely limited to FP. The training materials described in the reports are often part of the compendium of the MOPH's Health Promotions Department, but no additional reports or peer-reviewed publication are available to document the efficacy or impact of the programming.[16] Some formative research has been conducted on appropriate male target audiences (e.g., religious leaders) to effect behavior change around RMNCH and nutrition, with resulting draft messages,[17] but the impact of those messages on health behavior change through the proposed channel has not been assessed. Huber and colleagues tested a community-based intervention directed at volunteer-led support groups separately conducted for both men and women to improve FP utilization, showing encouraging results in the pilot phase.[18] However, whether there has been sustained

use of this model over time is unclear and, generally speaking, community-based models have not been institutionalized to the degree of facility-based interventions.

Similar to many countries with high TFR, Afghanistan has a "youth bulge." More than half of the population is younger than 19 years, with 26 percent between the ages of 10 and 19 years.[3] Within this life stage in Afghanistan, there are multiple major events, such as completion of education; development of trade skills; change in responsibilities within the family; and, particularly for women, marriage and childbearing. Despite these major changes and the role of this group as current and imminent health care consumers, there are very few data regarding their RMNCH knowledge, attitudes, and practices in Afghanistan. This gap is of great concern, as 42 percent of women ages 20 to 49 years interviewed in the 2015 Demographic and Health Survey reported being married by the age of 18 years.[3] More is known regarding media habits and preferences among young people in Afghanistan, with noted increasing mobile phone and social media use.[13,19] Media outlets target this large consumer base through youth-focused programming, summarized as being largely educational and in line with Afghan values.[19] However, few programs targeting youth have consistently addressed issues surrounding marriage or preparation for marriage, including FP/MNCH information. Thus, it is essential to better understand their health information and access needs, channels for engaging them on RH issues, and skills building and navigation of social and gender norms for increasing FP/RMNCH information among this group.

Purpose

The purpose of this study was to inform demand-generation programming targeting youth and men for FP/MNCH in Afghanistan. This formative research was conducted to provide information to guide the selection of social and behavioral change (SBC) topics and content, particularly surrounding norms that act as barriers to or facilitators of health behavior change; to identify priority communication channels; and to tailor messages for specific target audiences segmented by key sociodemographic characteristics. In particular, the study intended to clarify whether mobile phone-based communication programming is feasible and desirable among these target populations.

Objectives

The specific objectives for this study were to:

1. Describe current levels of knowledge, attitudes, practices, and norms toward various aspects of RMNCH, specifically FP and facility-based delivery of care, and to identify self-acknowledged knowledge gaps among different segments of youth (i.e., those ages 15 to 25 years) and adult men in Afghanistan.
2. Describe prior experience with and preferred content and channels for FP/RMNCH messaging and engagement.

2. METHODS

We conducted a cross-sectional mixed-methods formative assessment among male and female youth and male adults purposively recruited from selected provinces and organizations to provide a diverse snapshot of these groups in Afghanistan. We explored knowledge of and attitudes toward obstetric, newborn, and child care; birth spacing and FP use; health decision making within families; and acceptability of and trust in health messaging through various channels.

The study used quantitative methods (i.e., a questionnaire) to measure:

- Knowledge of and attitudes toward FP/RMNCH issues.
- Use of community and facility-based general health and FP/RMNCH services.
- Exposure to and sources of prior health messaging, particularly regarding FP/RMNCH.

- Preferred communication channels.
- Media platform usage and access.

Qualitative methods elicited:
- Perceived attitudes and norms that guide household health decision making.
- Perceived gaps in and ways to obtain FP/RMNCH knowledge.
- Desirability and likelihood of accessing health messaging through various media channels.

The qualitative component was made up of focus group discussions (FGDs) and in-depth interviews (IDIs). FGDs captured group perceptions of the available and most-desirable messaging and engagement approaches, as well as desired areas for further RMNCH messaging, among homogeneous groups. IDIs covered similar topics and explored the linkages between messages or engagement programs and health decision making. We selected IDI participants from the quantitative participants, with linkages across responses.

Study Sites and Population

We used convenience sampling to identify participants within the target populations. Provinces and cities where the target audiences could be readily accessed in sufficient numbers were purposively selected based on geographic and ethnic diversity, presence of the target institution or group, and security considerations. To effect some diversity in sampling at each site, we used various techniques, such as random selection through number generation within gathered groups (e.g., nursing students at the Ghazanfar Institute of Health Sciences [GIHS]) and the random walk technique for household selection for recruitment of internally displaced people (IDPs).

The study population was composed of two main groups: male and female youth ages 15 to 25 years and male adults ages 18 to 49 years, each identified and purposively recruited through organizations with predominantly youth or male populations (Table 2.1). Selected organizations included GIHS-affiliated schools, secondary schools, Afghan National Security Forces (ANSF) training sites, farmers' organizations, leaders within community or health shuras, and residents of IDP settlements.

Table 2.1. Sites and sample sizes for participant groups among men and youth in Afghanistan

Age Group	Target Group	Provinces	Sample Target
Male adult (18–40 years)	Farmers	Herat, Bamyan, Takhar	150/province
Male adult	Community leaders	Herat, Bamyan	150/province
Male adult	ANSF	Nangarhar, Kabul, Balkh	150/province
Male adult	IDP	Kandahar, Takhar, Nangarhar	150/province
Female and male youth (15–25 years)	GIHS (health professions school, post-secondary)	Kabul, Herat, Balkh, Kandahar	75 male/province, 75 female/province
Female and male youth (15–25 years)	Secondary school	Nangarhar, Balkh	150 male/province, 150 female/province
Female and male youth (15–25 years)	IDP	Kandahar, Nangarhar, Takhar	75 male/province, 75 female/province

The most important reason for including IDP settlements as a specified recruitment site was to ensure representation of the increasing number of people fleeing escalating conflict or natural disasters nationally.[20,21] IDPs are generally found in larger numbers in accessible urban and rural areas, allowing considerably easier access to populations that are otherwise widely geographically dispersed. Including

perspectives from rural areas is essential, as this segment represents approximately 74 percent of the national population, has greater barriers to accessing health care than urban residents and, consequently, has poorer MNCH indicators.[3] IDPs are also a vulnerable group based on economic and social barriers to health care, and the specific needs and ways to reach this group are poorly understood in Afghanistan, despite their increasing numbers.

Personnel

Study staff were male and female professionals fluent in Dari or Pashto and trained in human subjects research, informed consent, questionnaire administration, and qualitative methods.

Instrument Development

Quantitative measures assessed through the questionnaire included:

- Sociodemographic characteristics.
- Health care utilization and encounters with community-based providers.
- Awareness, knowledge, attitudes, and described experiences regarding FP/RMNCH care.
- Ownership and use of various communication modalities, including radio, television, and mobile phones.
- Health areas with a perceived need for more information.
- Most preferable sources for messaging.

For measures of FP/RMNCH knowledge that required participants to name a specific condition or action, the questions were asked in an open-ended fashion; participants were not read a list. Open-ended questions were asked about specific pregnancy and delivery complications, actions taken in response to a complication, actions to ensure a healthy pregnancy, duration of exclusive and complementary breastfeeding, appropriate umbilical cord care, and specific FP methods (demonstrating awareness).

Qualitative interview guides explored:

- Perceived health and FP/RMNCH knowledge levels and gaps, as well as perceived reliability of various health information sources.
- Attitudes and perceived norms within households for health care access and payment.
- Perceived gaps in FP/RMNCH knowledge, as well as additional knowledge needed to make actionable change.
- Preferred sources of health (specifically FP/RMNCH) information and engagement.
- Feasibility and trust in information conveyed by mass media (e.g., radio and television).
- Feasibility and willingness to pay for information conveyed by mobile technology.

Adult male participants were additionally asked about the health decision-making process within their families, norms surrounding spousal roles, use of care surrounding the birth of their youngest child, and women's level of access to mass media and mobile technology in their families.

All draft questionnaires and interview guides were pretested for content and face validity in local languages on 40 volunteers not considered later for participation.

Study instruments are included in Annex 1.

Recruitment and Data Collection

Quantitative Component

For the quantitative component, youth were recruited from two sites: 1) schools with students in the desired age range and 2) informal educational programs and other youth-oriented programs in IDP settlements in major urban areas. Students in all career tracks (e.g., midwifery, laboratory technologist) at the allied health professions at GIHS schools in Balkh, Herat, Kabul, and Kandahar were proportionally divided by career track at each site, and the sample size was randomly selected from each track for potential participation in the quantitative survey. A similar approach was used at selected secondary schools in Balkh and Nangarhar Provinces. For all educational settings, following appropriate provincial-level permissions, we conducted a study overview for classes considered for enrollment. Following the presentation, students were divided by career track (for health professions schools) or class (for secondary schools); counted, with potential participants and alternates randomly selected; and, of those selected, offered participation. Study staff of the same sex met with each potential participant in a private room or area, conducted informed consent, and then administered the questionnaire to consenting participants.

Similar recruitment approaches were used for men (ages 18 to 49 years) gathered for training or other group events. For organizations with multiple locations within one province, recruitment sites were randomly selected prior to site visits. Following receipt of appropriate government and organizational permissions, trained male staff presented a study overview to men gathered in a large meeting room within the respective organizations. Men were then counted, potential participants and alternates were randomly selected, and those selected were offered participation. Interested men accompanied staff to a private room, where they completed informed consent and questionnaire administration.

For both youth and adult IDP participants, IDP settlements were identified and selected based on reference from the United Nations High Commissioner for Refugees and from similar groups that have relationships with formal settlements and their internal leaders. For residents of IDP settlements, we engaged local shura leaders, presented the study, and obtained permissions to recruit young people within the community. Following permission and community notification, a household survey was performed by selecting a central landmark and, using the random walk technique, offering enrollment to all residents who met eligibility criteria, until the sample size was reached. At the household level, the study manager met with the head of household, presented the study, and requested permission to present the study to young men and women in the house (using sex-matched study staff in deference to cultural norms). Where adult IDP populations were sampled, male study staff presented the study to men in selected households who, if interested in participation, provided informed consent and completed the questionnaire in a private room.

For all quantitative groups, following informed consent and assignment of a unique study number, trained staff administered the tablet-based written questionnaire. In areas where tablet use represented a security risk, paper-based instruments were used. Participants were counseled that they could ask questions about issues raised in the questionnaire that they did not understand or found objectionable and could decline responding without providing a reason. Following questionnaire administration, participants were asked if they had any questions regarding health issues raised in the questionnaire. Trained staff provided participants with written and verbal information and referred participants as needed to the nearest health facility for complicated queries or care needs. Individuals who declined participation, either at selection or when they met privately with the study staff, were enumerated; no sociodemographic data were collected. Alternates were selected in the order chosen until the appointed sample size was reached.

Qualitative Component

For IDIs, we purposively selected a small group of quantitative participants by sex (youth participants), age, geographic location, urban/rural setting, and marital status/number of children (Table 2.2). A total of 49 IDIs were conducted. Flexibility was provided in terms of participant age (i.e., allowing plus or minus two years) or number of children (i.e., allowing for one additional child) around inclusion criteria and the available quantitative sample in each site to complete the designated sample size.

Table 2.2. Inclusion criteria for in-depth interview participants (n=49)

Group	Province	Descriptors
Farmers	Herat	• Married man, age 20–25 years, no more than 2 children with child <2 years old • Married man, age 30–35 years, >4 children • Married or widowed man, completed primary school, >2 children, experienced death of spouse or child
Farmers	Bamyan	• Married man, age 20–25 years, no more than 2 children with child <2 years old • Married man, age 30–35 years, >4 children • Married or widowed man, completed primary school, >2 children, experienced death of spouse or child
Farmers	Takhar	• Married man, age 20–25 years, no more than 2 children with child <2 years old • Married man, age 30–35 years, >4 children
Community leaders	Herat	• Married man, age 20–25 years, high school graduate • Married man, age 30–40 years, no formal education, >3 children; • Married man, age 25–30 years, educated in madrassah, >2 children
Community leaders	Bamyan	• Married man, age 30–40 years, no formal education, >3 children • Married or widowed man, age 25–30 years, completed primary school, experienced death of spouse or child
IDPs (men)	Kabul	• Married man, age 20–25 years, IDP due to insecurity, no more than 2 children with child<2 years old • Married or widowed man, age 30–35 years, IDP due to natural disaster (e.g., flooding, drought), >2 children, experienced death of spouse or child
IDPs (men)	Kandahar	• Married man, age 20–25 years, IDP due to insecurity, no more than 2 children with child<2 years old • Married or widowed man, age 30–35 years, IDP due to natural disaster (e.g., flooding, drought), >2 children, experienced death of spouse or child • Married man, age 25–30 years, completed primary school, IDP due to insecurity, >2 children
IDPs (men)	Nangarhar	• Married man, ages 20-25 years, IDP due to insecurity, no more than 2 children with child <2 years old • Married or widowed man, age 30–35 years, IDP due to natural disaster (e.g., flooding, drought), >4 children, completed primary and possibly some secondary school
ANSF	Kabul	• Unmarried or engaged man, 20–25 years, no formal education • Married man, 30–35 years, completed secondary school, ≥3 children

Group	Province	Descriptors
ANSF	Balkh	• Unmarried or engaged man, age 20–25 years, no formal education • Married man, age 30–35 years, completed secondary school, ≥3 children • Married man, age 25–30 years, no formal education, <3 children with child <2 years of age
IDPs (youth, male and female)	Kandahar	• Unmarried female youth, age 15–18 years, no formal education, IDP due to insecurity • Unmarried male youth, age 15–18 years, no formal education, IDP due to natural disaster • Unmarried or engaged male youth, age 18–20 years, completed primary or some secondary school, IDP due to insecurity
IDPs (youth, male and female)	Takhar	• Unmarried female youth, age 15–18 years, no formal education, IDP due to insecurity • Unmarried male youth, age 15–18 years, no formal education, IDP due to natural disaster • Unmarried or engaged male youth, age 18–20 years, completed primary or some secondary school, IDP due to insecurity
IDPs (youth, male and female)	Nangarhar	• Married female youth, age 15–18 years, no formal education, IDP due to insecurity, <3 children with child age 2 years or less • Unmarried male youth, age 15–18 years, completed primary or some secondary school, IDP due to natural disaster
Secondary school students	Nangarhar	• Male student, age 15–17 years; female student, age 17–20 years • Female student, age 15–17 years
Secondary school students	Balkh	• Male student, age 15–17 years • Female student, age 15–17 years
GIHS students	Kabul	• Male nursing student, age 16–19 years • Female midwifery student, age 16–19 years
GIHS students	Herat	• Male pharmacy student, age 16–19 years • Female nursing student, age 16–19 years • Male physical therapy student, age 18–20 years
GIHS students	Balkh	• Male nursing student, age 16–19 years • Female nursing student, age 16–19 years • Female physical therapy student, age 18–20 years
GIHS students	Nangarhar	• Male pharmacy student, age 16–19 years • Female midwifery student, age 16–19 years

For IDI recruitment, quantitative participants were assessed for IDI selection criteria following questionnaire completion. After validation with the study manager to prevent duplication, those meeting inclusion criteria were offered IDI participation. The study staff member presented an overview of the IDI, including the content of the guide and the requirement for recording the session, and then conducted informed consent. Following verbal informed consent, the participant chose a pseudonym for reference during the recorded interview; the study number issued for the quantitative component was retained to allow data linkage. The staff member administered the interview guide to the participant in a conversational approach and probed unusual responses, with the session digitally recorded.

Eleven FGDs were conducted. One or two FGDs were conducted for each specific group (e.g., religious leaders, midwifery students), with groups being homogeneous by sex and, where possible, age (Table 2.3).

Table 2.3. Focus group discussion sample size and location (n=67 participants)

Group	Province	District	Number
Female GIHS students	Kabul	Kabul City	1
Male GIHS students	Herat	Herat City	1
Female secondary school students	Nangarhar	Kama	1
Male secondary school students	Balkh	Mazar-i-Sharif City	1
Male IDP youth	Kandahar	Marouf	1
Female IDP youth	Balkh	Mazar-i-Sharif City	1
Farmers' group members	Bamiyan	Yakawlang	2
ANSF	Kabul	Kabul City	1
Male IDPs	Nangarhar & Takhar	Baharak (Takhar) & Kama (Nangarhar)	2
Community leaders	Herat	Injil	1

To select FGD participants at the appointed sites (e.g., GIHS in a specific city), study staff met with individuals not selected for the quantitative component and described the qualitative component and FGDs. Ten interested individuals were selected at random and invited by a sex-matched study staff member to a private setting, where informed consent was obtained. Once 6 to 10 participants consented for a given FGD, they were invited to convene in a private room, with a moderator and session audio recorder of the same sex. The moderator greeted participants, performed a brief icebreaker during which participants chose pseudonyms, and provided basic group instructions. The moderator administered the question guide and probed regarding unexpected responses or areas of disagreement among group members. The session recorder, who was another study staff member, noted areas of agreement or disagreement and nonverbal communication. At the conclusion of the FGD, the digital recorder was stopped and participants were thanked for their time.

For both IDIs and FGDs, digital files were checked for quality and then uploaded to password-protected computers in the central study office. Transcription and translation were performed in the study office with all identifying features removed from the final English transcript. After final transcript approval, the digital files were erased. In some cases, participants were called by interviewers for repeat probing to ensure consistent quality standards across interviews.

Sample Size Justification

We based the sampling strategy for this formative study on feasibility and interest in including study populations with broad geographic, ethnic, and sociodemographic diversity. For the quantitative component, two separate calculations were performed. For youth, data available at the time of protocol development indicated that 62 percent of female youth surveyed in Kabul reported not having access to a health information source.[22] We aimed to determine whether a difference of at least 20 percent was present between similar youth samples from different regions (e.g., youth recruited from secondary schools in different provinces) and between dissimilar youth samples in the same region (e.g., IDP youth versus school-based youth). The rationale for detecting a difference of 20 percent was that it was considered a meaningful difference (in conjunction with qualitative data) by an expert consensus; such a difference would require planned programming to be modified to ensure that information was appropriate between subgroups. Calculations assumed that one group had a knowledge level of 62 percent, a 95 percent confidence interval, and 90 percent power (two-sided alpha=0.05), resulting in a sample size of 139 per recruitment site. The sample size was increased to 150 per site to account for the uncertainty of assumptions derived from only one site (i.e., Kabul), to account for questionnaires with incomplete information, and to permit comparisons between specific groups (e.g., GIHS students in different cities).

For men, little information is available regarding levels of FP/RMNCH information receipt and associated knowledge. We conservatively estimated that 69 percent of men have received RH information, based on national levels of radio ownership.[19] Based on this assumption and the previously described rationale, detection of a 20 percent difference between subgroups, with a 95 percent confidence interval and 90 percent power, required a sample size of 135 per site. The sample size was increased to 150 per site for reasons previously noted. Similar to the youth sample, the sample size for men was divided by recruitment site to allow comparisons between male adult groups by province and group membership (e.g., farmers' union) to better guide programming for specific subgroups.

Data Analysis

Quantitative Analysis

STATA® version 13 (StataCorp LP, College Station, Texas, USA) was used for quantitative statistical analysis. Descriptive statistics were generated for each large group (i.e., men, school-based youth, IDP youth) using percentages and counts. Differences across groups were assessed to help interpret estimates; however, we did not conduct a weighted analysis to properly represent the different subgroups in the combined data set, as information regarding the size of the population represented by each group could not be collected within the scope of this study. Table 2.4 summarizes key outcome variables and the analytic approach.

Table 2.4. Quantitative analysis approach for key outcome measures

Outcome Measure	Analytic Approach
Prior exposure to FP/RMNCH health communication messages	Proportions pooled overall for each target group (i.e., youth and male adults) and analyzed by key sociodemographic variables, such as province of origin, age, channel (e.g., radio), and sex (for youth)
Correct knowledge of key FP/RMNCH information: • Antenatal care needs • Warning signs during pregnancy • Warning signs during labor • Newborn cord care • Modern FP method use and side effects • Breastfeeding practices	Proportions overall by target group (pooled) and stratified by key variables (e.g., educational level, sex)
Exploratory variable: perceived gaps in FP/RMNCH knowledge	Counts and proportions overall by group and stratified by key variables (e.g., province of origin, age, education, sex)
Preferred media channel for health messages	Counts and proportions overall by group and stratified by key sociodemographic variables (e.g., province of origin, age, education, sex)
Levels of access to various media platforms for health messages (e.g., radio, television, mobile phone, Internet)	Counts and proportions overall by group and stratified by key sociodemographic variables (e.g., province of origin, age, education, sex)
Most trusted source for FP/RMNCH information	Counts and proportions overall by group and stratified by key sociodemographic variables (e.g., province of origin, age, education, sex)
Interest in and willingness to pay for FP/RMNCH messages through mobile phone-based programming	Counts and proportions overall by group and stratified by key sociodemographic variables (e.g., province of origin, age, education, sex)

For the key FP/RMNCH knowledge variables and exposure to health messaging, comparisons were made within each of the three groups to detect differences by province, age, education level, and other characteristics that emerged as potential differentiators. Appropriate tests of association were used for bivariate (e.g., chi-square test, t-test) and multivariable (e.g., logistic regression) analysis to determine correlates of correct FP/RMNCH knowledge measures, health messaging exposure through the media, and other pertinent outcomes. Missing data were quantified. If less than 5 percent of responses were missing for a given covariate, analysis proceeded without adjustment. If more than 5 percent were missing, an assessment was undertaken to determine whether those with missing data were disproportionately representative of a certain groups or region; those differences were mentioned as a limitation in the analysis. Statistical significance was defined as $p<0.05$ for all statistical tests.

Qualitative Analysis

Applied thematic analysis was used to analyze the qualitative data from 49 IDIs and 12 FGDs. We used the qualitative data software program ATLAS.ti 8 (Scientific Software Development GmBH, Berlin, Germany) to organize all textual data, prepare the data for analysis, and segment text. An initial codebook containing a priori codes related to the overall study objectives as well as topics explored in the IDIs and FGDs was developed and applied to the data. To ensure reliability between coders, three trained analysts periodically coded a sample of transcripts (approximately 15 percent of total transcripts) and then compared independent interpretations of the data. The team discussed coding discrepancies to ensure a common understanding of the codebook and interpretation of the text going forward. Analysts segmented text according to how the information addressed the key objectives and topics, identified data-derived codes through an inductive process of reading through the transcripts, tentatively identified content-based codes, and segmented text as it related to these codes. As new codes were identified, previously coded text was reviewed and recoded as necessary. Once all the transcripts had been coded, analysts produced textual coding reports. Data-reduction techniques were then used to examine codes in detail for subthemes and patterns across the IDIs and FGDs. Descriptive summary reports identifying the overall themes related to the study objectives were then developed.

Ethics Review

The research study was reviewed and approved by the Protection for Human Subjects Committee of FHI 360 on March 8, 2016, and the institutional review board of the MOPH on May 23, 2016 (Annex 2). Both ethical review bodies approved an amended protocol and instruments in January 2017, prior to initiation of data collection.

3. QUANTITATIVE RESULTS

Youth

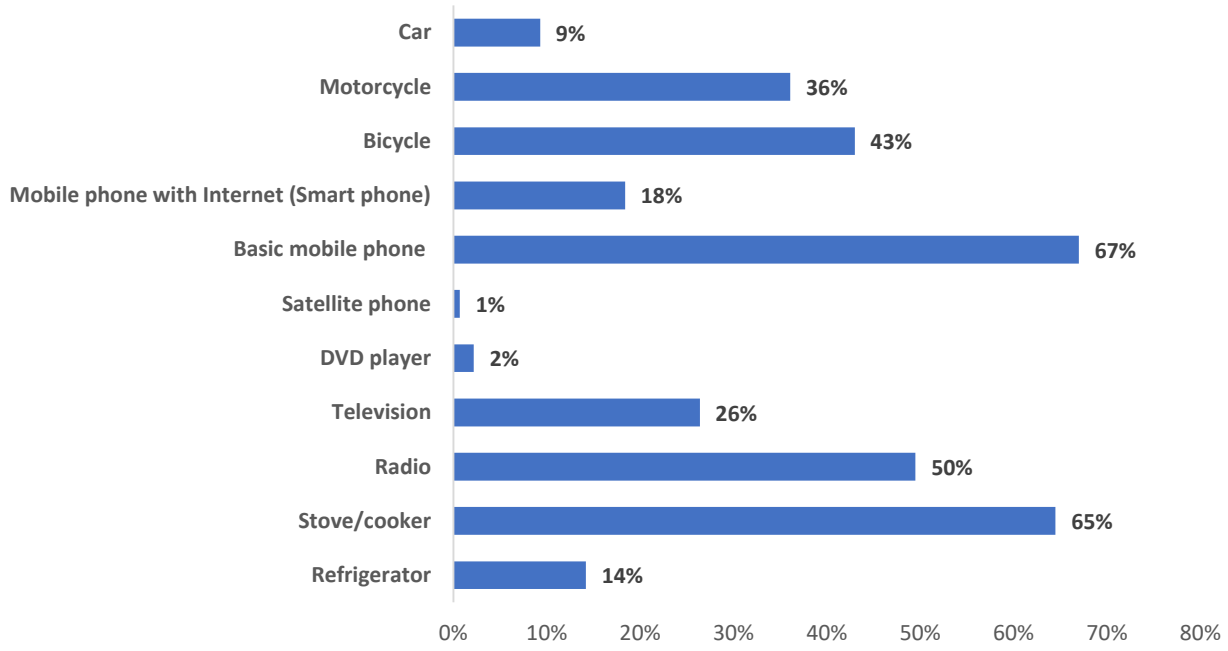
We initially segmented youth by those in secondary school or above and those who were IDPs, based on known disparities in resources and educational attainment, as well as on sampling site differences. We analyzed the overall sociodemographic features for these groups. We then segmented the groups by sex and, for IDP youth, by marital status within these larger populations to increase homogeneity when describing key FP/RMNCH knowledge, attitudes, and practices and health communication preferences; however, these sample sizes were smaller, as we did not select participants or base sample size on this additional segmentation.

IDP Youth

A total of 452 IDP youth (ages 15–25 years) were surveyed in Kandahar, Nangarhar, and Takhar Provinces; 225 (49.8 percent) were male and 227 (50.2 percent) were female. Nearly half (45.9 percent) were married, which was more likely for female than male youth (52.6 percent versus 39.1 percent, p=0.004). Most participants (91.8 percent) were born in Afghanistan, with the remainder born in Pakistan (7.3 percent) and Iran (0.9 percent). Nearly half (44.4 percent, n=184) reported living in the province of their birth, suggesting displacement within the same province.

Day labor (35.0 percent) and agriculture/animal husbandry (34.3 percent) were the most common reported sources of household income prior to displacement, with 11.8 percent and 11.3 percent reporting general business/trade sources and civil service, respectively. One-quarter (25.9 percent) reported not knowing their household's current monthly income; of those reporting an estimate (n=334), the mean amount was 11,719 Afghanis (Afs) (standard deviation [SD]: +14,461) and the median amount was 8,750 Afs (interquartile range [IQR]: 5,500–11,000). A snapshot of household wealth indicators is provided in Figure 3.1.

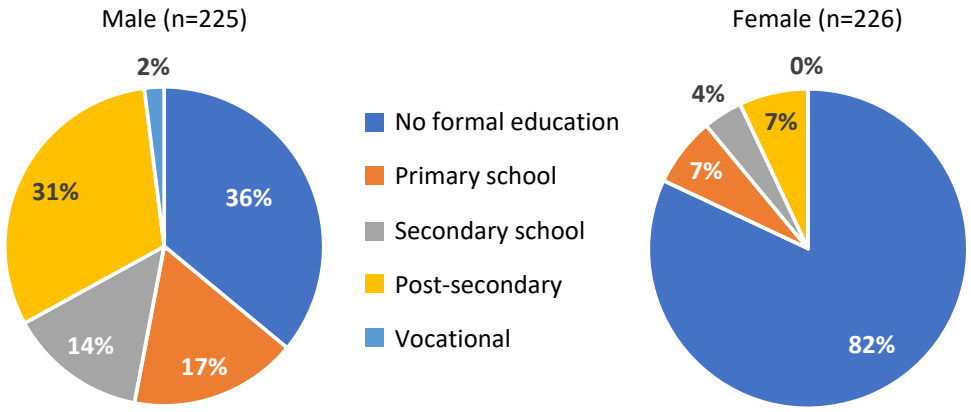
Figure 3.1. Household wealth indicators among IDP youth (Afghanistan, 2017) (n=451)



Main household water sources prior to displacement were surface water (21.5 percent), tube well/ borehole (17.5 percent), dug well (14.9 percent), protected well (14.6 percent), and public tap/pipe (9.8 percent).

Most female IDP youth had no formal education (Figure 3.2), while two-thirds of male IDP youth reported at least some educational attainment.

Figure 3.2. Highest education level attained among IDP youth, by sex (Afghanistan, 2017) (n=451)



Being married (p=0.004) and having any formal education (p<0.001) diverged widely by sex (Figure 3.2); thus, we segmented the IDP youth analysis by sex. We did not segment by education because of a very low proportion of educated female youth. We segmented IDP youth by marital status based on immediate need to make FP/RMNCH decisions versus a probable future need for unmarried youth.

Table 3.1. Sociodemographic characteristics among IDP youth from three provinces (Kandahar, Nangarhar, and Takhar), by sex and marital status (Afghanistan, 2017) (n=452)

Characteristic	Male (n=225)	Female (n=227)	Married (n=207)	Unmarried (n=247)
Age (mean, SD)	21.0, 3.3	21.8, 3.0	23.2, 2.4	19.9, 2.7
Age at marriage (mean, SD)	19.9, 2.7	16.7, 2.4	N/A	N/A
	% (n)	**% (n)**	**% (n)**	**% (n)**
Married	39.1 (88)	52.6 (119)	--	--
Formal education	64.4 (145)	17.7 (40)	30.0 (62)	50.4 (123)
Living in province of birth	36.6 (75)	52.2 (109)	37.8 (74)	50.5 (110)
Able to read full sentence	66.2 (96/145*)	26.8 (11/41*)	48.4 (30/62*)	62.1 (77/124*)
Television in household	27.6 (62)	25.2 (57)	17.4 (36)	34.0 (83)
Radio in household	52.4 (118)	46.5 (105)	37.7 (78)	59.4 (145)

*Denominator: IDP youth with any formal education

Table 3.1 displays traits specific to each segmented group. Women generally married at a younger age than men and, among both sexes, having a formal education was no guarantee of literacy. Married youth had less household access to media sources than unmarried youth.

Media exposure and preferences among IDP youth by sex and marital status

Print media, like newspapers and magazines, were not widely read by IDP youth of either sex (Table 3.2). Unmarried youth tended to read print media more than married peers. Women generally had lower rates of radio use, while television viewing was similar between men and women.

Table 3.2. Media exposure among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Media Source	Daily	At Least Weekly	Less than Weekly	Not at All
Newspapers/magazines				
Male	2.0%	8.5%	11.0%	78.6%
Female	0%	1.0%	1.9%	97.1%
Married	0.5%	3.7%	3.7%	92.0%
Unmarried	1.4%	5.4%	8.6%	84.6%
Radio				
Male	34.7%	20.0%	1.8%	43.6%
Female	21.7%	7.5%	6.2%	64.6%
Married	16.9%	11.1%	6.8%	65.2%
Unmarried	37.7%	16.0%	1.6%	44.7%
Television				
Male	21.8%	7.6%	0.4%	70.2%
Female	23.5%	4.9%	0.9%	70.8%
Married	15.5%	5.8%	1.5%	77.3%

Preferred times for media use varied somewhat by sex and marital status; however, the majority of television and radio users preferred the 6 to 9 PM prime time slot (Figures 3.3 and 3.4).

Figure 3.3. Most frequent radio and television viewing times among male and female IDP youth (Afghanistan, 2017) (n=207 for radio and 133 for television)

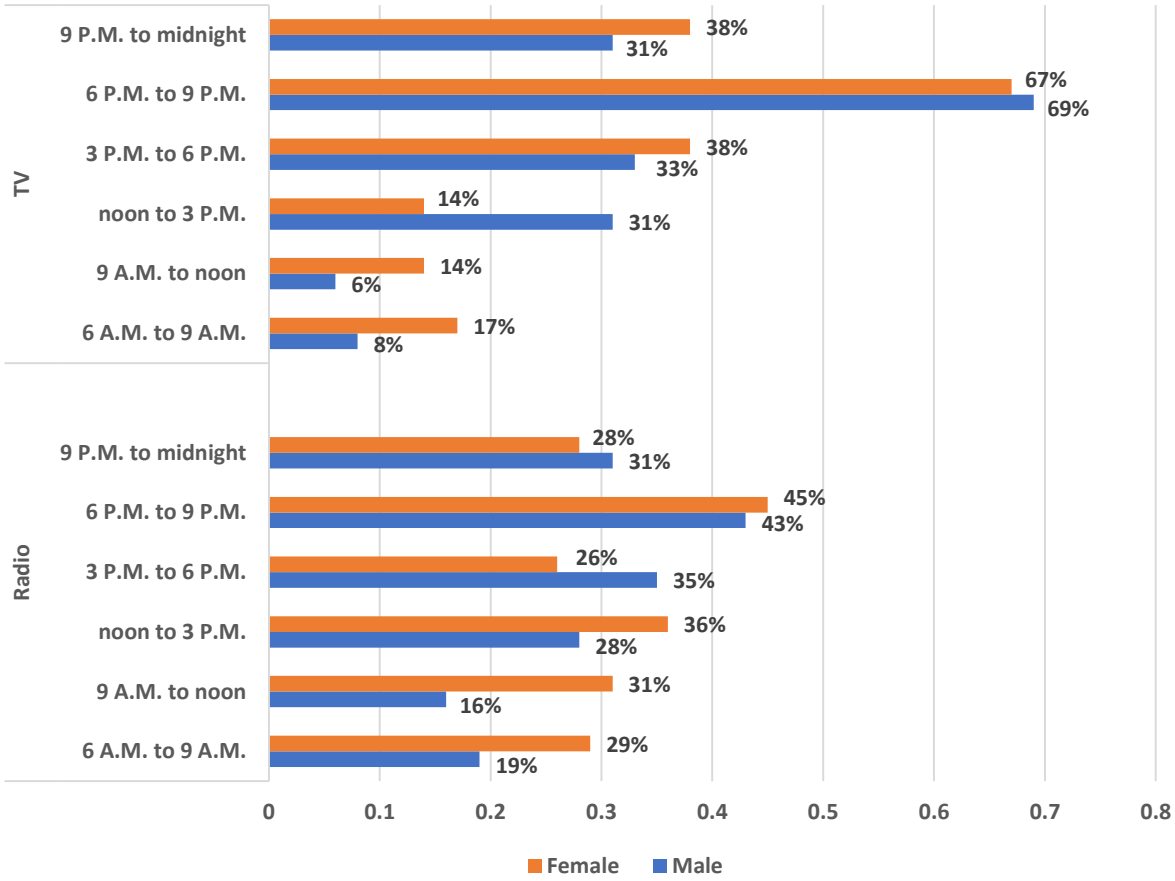
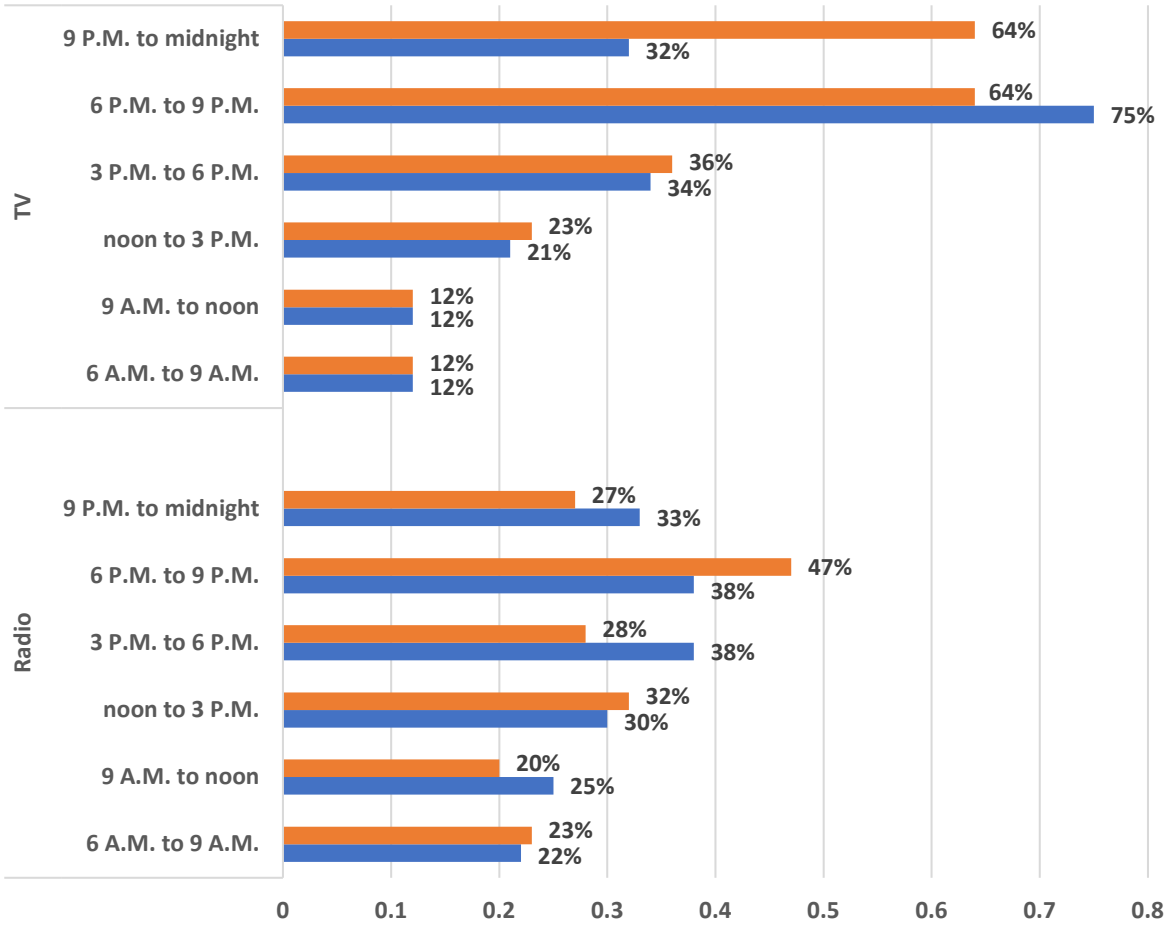


Figure 3.4. Most frequent radio and TV viewing times; married and unmarried IDP youth, Afghanistan, 2017 (n=207 for radio and 133 for television)



Radio and television programming preferences differed by sex, but less so by marital status (Table 3.3).

Table 3.3. Television and radio programming preferences among IDP youth reporting media exposure in the past month, by sex and marital status (Afghanistan, 2017) (n=207)

Program Type	Male % (n)	Female % (n)	Married % (n)	Unmarried % (n)
Radio	**(n=127)**	**(n=80)**	**(n=135)**	**(n=72)**
International news	60.6 (77)	37.5 (30)	55.6 (75)	44.4 (32)
National news	65.4 (83)	27.5 (22)	51.1 (69)	50.0 (36)
Local news	29.1 (37)	36.3 (29)	32.6 (44)	30.6 (22)
Music	51.2 (65)	75.0 (60)	60.7 (82)	59.7 (43)
Religious programming	13.4 (17)	22.5 (18)	17.8 (24)	15.3 (11)
Sports	48.0 (61)	13.8 (11)	37.0 (50)	30.6 (22)
Culture	11.8 (15)	2.5 (2)	8.9 (12)	6.9 (5)
Political debates	5.5 (7)	—	3.7 (5)	2.8 (2)
Entertainment	19.7 (25)	17.5 (14)	20.0 (27)	16.7 (12)
Health	12.6 (16)	8.8 (7)	12.6 (17)	8.3 (6)

Program Type	Male % (n)	Female % (n)	Married % (n)	Unmarried % (n)
Social	0.8 (1)	13.8 (11)	5.2 (7)	6.9 (5)
Drama serials	3.9 (5)	25.0 (20)	11.1 (15)	13.9 (10)
Television	**(n=67)**	**(n=66)**	**(n=86)**	**(n=47)**
International news	68.7 (46)	40.9 (27)	62.8 (54)	40.4 (19)
National news	70.2 (47)	40.9 (27)	57.0 (49)	53.2 (25)
Local news	29.9 (20)	28.8 (19)	32.6 (28)	23.4 (11)
Drama serials	73.1 (49)	86.4 (57)	83.7 (72)	72.3 (34)
Music programs	40.3 (27)	60.6 (40)	53.5 (46)	44.7 (21)
Religious programs	14.9 (10)	10.6 (7)	14.0 (12)	10.6 (5)
Sports	58.2 (39)	12.1 (8)	39.5 (34)	27.7 (13)
Entertainment	29.9 (20)	18.2 (12)	24.4 (21)	23.4 (11)
Movies	35.8 (24)	51.5 (34)	46.5 (40)	38.3 (18)
Political debate	7.5 (5)	3.0 (2)	7.0 (6)	2.1 (1)
Educational programs	4.5 (3)	6.1 (4)	3.5 (3)	8.5 (4)

Overall, 54.9 percent (n=73/133) of IDP youth who watched television had viewed health programming in the past month. Exposure did not differ by marital status (57.5 percent for married versus 57.5 percent for unmarried) but was more likely for male than female youth (68.7 percent versus 40.9 percent, p=0.001). Table 3.4 displays health topics that IDP youth recalled from radio and television.

Table 3.4. Health topics reported among IDP youth exposed to health messages broadcast on radio and television in the past month, by sex and marital status (Afghanistan, 2017) (n=89 for radio and n=73 for television)

Topic	Radio Listeners				Television Viewers			
	Male (n=59)	*Female (n=30)*	*Married (n=33)*	*Unmarried (n=56)*	*Male (n=46)*	*Female (n=27)*	*Married (n=27)*	*Unmarried (n=46)*
Vaccination	72.9% (43)	66.7% (20)	63.6% (21)	75.0% (42)	67.4% (31)	51.9% (14)	55.6% (15)	65.2% (30)
Influenza	30.5% (18)	40.0% (12)	33.3% (11)	33.9% (19)	30.4% (14)	37.0% (10)	29.6% (8)	34.8% (16)
Family Planning	22.0% (13)	6.7% (2)	15.2% (5)	17.9% (10)	50.0% (23)	25.9% (7)	48.2% (13)	37.0% (17)
Handwashing /hygiene	37.3% (22)	40.0% (12)	33.3% (11)	41.1% (23)	65.2% (30)	18.5% (5)	48.2% (13)	47.8% (22)
Nutrition	25.4% (15)	20.0% (6)	21.2% (7)	25.0% (14)	52.2% (24)	18.5% (5)	33.3% (9)	43.5% (20)
High blood pressure	11.9% (7)	20.0% (6)	15.2% (5)	14.3% (8)	13.0% (6)	11.1% (3)	11.1% (3)	13.0% (6)
Smoking prevention	10.2% (6)	13.3% (4)	12.1% (4)	10.7% (6)	15.2% (7)	22.2% (6)	22.2% (6)	15.2% (7)

Exposure to health programming on the radio was significantly associated with internal IDP status (57.0 percent for IDPs versus 27.5 percent for non-IDPs, p<0.001) and with province (49.4 percent for Kandahar versus 43.4 percent for Nangarhar versus 21.4 percent for Takhar, p<0.003) in bivariate analysis. Older age (mean age of 22.0 versus 21.0 years, p=0.02), male sex (69.7 percent versus 40.6 percent, p=0.001),

and province (75.9 percent in Nangarhar versus 53.2 percent in Kandahar versus 36.4 percent in Takhar, p=0.02) were significantly associated with IDP youth viewing a health program on television. Most IDP youth (75 percent) and school-based youth (81 percent) reported having their own mobile phone. Table 3.5 summarizes mobile phone ownership by various demographic variables.

Table 3.5. Mobile phone ownership among IDP youth, segmented by sex and marital status and disaggregated by various factors (Afghanistan, 2017) (n=451)

Sociodemographic Characteristic	Male (n=225)	Female (n=226)	p-value	Married (n=207)	Unmarried (n=244)	p-value
Overall	97.3% (210)	51.6% (112)	***	74.4% (154)	72.5% (177)	NS
Province						
Kandahar	98.7% (74)	55.4% (41)	***	82.9% (29)	74.8% (86)	NS
Nangarhar	94.7% (71)	42.6% (29)	***	58.0% (40)	73.2% (60)	NS
Takhar	98.7% (74)	56.0% (42)	***	82.5% (85)	66.0% (31)	*
Age, mean (SD)	21.1 (3.2)	22.1 (2.7)	**	23.4 (2.3)	19.9 (2.7)	***
Household income (Afs), mean (SD)	10818 (9768)	9159 (9319)	NS	8892 (7726)	11514 (10899)	*
Sought care from medical provider, past 6 months	37.4% (82)	58.9% (66)	***	49.4% (76)	64.9% (72)	NS
Any formal education	98.6% (143)	20.5% (23)	***	36.4% (56)	62.1% (110)	***
Sex						
Male	--	--		97.7% (86)	97.1% (133)	NS
Female	--	--		59.1% (68)	43.1% (44)	**
Marital status						
Married	97.7% (86)	60.7% (68)	***	--	--	
Unmarried	97.1% (133)	44.8% (47)	***	--	--	

*p<0.05; **p<0.01; ***p<0.001; ‡ large proportion of participants stating didn't know; NS=not statistically significant.

For radio programming, women were more likely to listen to music (p=0.001) and drama programs (p<0.001), while men were more likely to listen to international news (p=0.001), national news (p<0.001), and sports programs (p<0.001).

About 20 percent of both sexes mentioned listening to general entertainment, but nearly twice as many women as men reported listening to religious programming (p=0.09). Radio program choices and stations did not differ by marital status, except for international news, which was more popular among married youth (p=0.01). Radio station choices mentioned by IDP youth reflected sampling sites, as many were provincial or regional stations. There were some differences in station preference by sex, with Shamshad, En'ekas, and BBC the most popular stations among male IDPs and Hewad, Shamshad, and Mermun the most popular among female IDPs. There was greater variety in station preference among unmarried IDP youth, with sizeable proportions listening to BBC and Mermun radio, while both married and unmarried youth preferred Shamshad, E'nekas, and Hewad (data not shown).

In bivariate analyses, younger age (mean of 20.9 versus 21.7 years, p=0.01), male sex (54.7 percent versus 29.2 percent, p<0.002), province, and having ever attended school (54.9 percent versus 33.1 percent, p<0.001) were associated with listening to the radio at least weekly among IDP youth; IDP youth from Kandahar (55.3 percent) and Nangarhar (53.6 percent) were more likely to listen to the radio than those from Takhar (16.7 percent, p<0.001).

Television programming preferences were similar between sexes for local news and religious programming. However, female IDP youth preferred dramas (p=0.06), music (p=0.02), and movies (p=0.07), while male youth preferred international news, national news, and sports programming (all p<0.001). Married IDP youth preferred various entertainment and sports programs, but the only statistically significant difference between married and unmarried IDP youth was for viewing international news (p=0.01). Television channel preference differed by sex, as male IDP youth preferred Shamshad and Lemar, with some mentioning Hewad and Tolo, and female youth preferred Tolo, then Lemar, Khurshid, and Shamshad. Married and unmarried youth largely agreed on television stations, with Tolo, Lemar, and Shamshad the most popular, followed by Hewad, which was more popular among unmarried youth (data not shown).

Just under half (43.0 percent, n=89/207) of IDP youth who listened to the radio reported listening to a health program in the past month. A higher proportion of male than female youth reported this (46.5 percent versus 37.5 percent, p=0.21), but proportions were similar by marital status (45.8 percent for married versus 41.5 percent for unmarried).

Overall, 54.9 percent (n=73/133) of IDP youth who watched television had viewed health programming in the past month. Exposure did not differ by marital status (57.5 percent for married versus 57.5 percent for unmarried) but was more likely for male than female youth (68.7 percent versus 40.9 percent, p=0.001). Table 3.4 displays health topics that IDP youth recalled from radio and television.

Exposure to health programming on the radio was significantly associated with internal IDP status (57.0 percent for IDPs versus 27.5 percent for non-IDPs, p<0.001) and with province (49.4 percent for Kandahar versus 43.4 percent for Nangarhar versus 21.4 percent for Takhar, p<0.003) in bivariate analysis. Older age (mean age of 22.0 versus 21.0 years, p=0.02), male sex (69.7 percent versus 40.6 percent, p=0.001), and province (75.9 percent in Nangarhar versus 53.2 percent in Kandahar versus 36.4 percent in Takhar, p=0.02) were significantly associated with IDP youth viewing a health program on television. Most IDP youth (75 percent) and school-based youth (81 percent) reported having their own mobile phone. Table 3.5 summarizes mobile phone ownership by various demographic variables.

Among IDP youth, mobile phone ownership was significantly more likely among male youth for all variables except having seen a health care provider in the past six months. Across variables, married female youth had higher rates of mobile phone ownership than female youth in most other comparison groups. However, female youth and married youth reporting any formal education had much lower rates of mobile phone ownership. Some of the differences were driven by the higher proportion of women being married relative to men; for example, 71.0 percent of married youth in Nangarhar were women compared with 49 to 51 percent in the two other provinces.

Most (81 percent) of the IDP youth who did not own a mobile phone reported being able to use a relative's or friend's phone. Only 73 percent of married youth reported being able to access a phone, compared with 87 percent of unmarried youth; this comparison was largely confined to women due to high phone ownership rates among men. Only 15 percent of IDP youth reported prior Internet use on smart phones, tablets, or computers, which was strongly correlated with male sex (25.3 percent for male versus 4.4 percent for female, p<0.001) and less so by marital status (19.7 percent for unmarried versus 9.2 percent for married, p=0.002). Male sex remained independently associated with prior Internet use when adjusted for age and any formal education (adjusted odds ratio [AOR]=3.12, 95 percent confidence interval [CI]: 1.46–7.76), but marital status was not independently associated with Internet use in similar adjusted analyses.

Health service-seeking behavior

Nearly half (48 percent, n=216) of IDP youth reported receiving care from a health provider in the past six months, and this was significantly more likely for female than male IDP youth (58.0 percent versus 36.9 percent, p<0.001) but did not differ by marital status (49.8 percent for married versus 45.5 percent for unmarried, p=0.82). Among those receiving care in the past six months, most received counseling, with some differences by sex (90.4 percent for male versus 81.7 percent for female, p=0.08) and marital status (80.6 percent for married versus 89.2 percent for unmarried, p=0.08). Common counseling topics are displayed in Table 3.6.

Table 3.6. Counseling topics provided by health care providers to IDP youth receiving health counseling in the past six months, by sex and marital status (Afghanistan, 2017) (n=182)

Topic	Male (n=75)	Female (n=107)	Married (n=83)	Unmarried (n=99)
Health maintenance	50.7% (38)	51.4% (55)	44.6% (37)	56.6% (56)
Smoking cessation	33.3% (25)	10.3% (11)	24.1% (20)	16.2% (16)
Accident prevention	25.3% (19)	25.2% (27)	26.5% (22)	24.2% (24)
Stress reduction	25.3% (19)	20.6% (22)	22.9% (19)	22.2% (22)
Depression/mental health	14.7% (11)	25.2% (27)	18.01% (15)	23.2% (23)
Family planning	8.0% (6)	10.3% (11)	10.8% (9)	8.1% (8)
Women's health	10.7% (8)	26.2% (28)	19.3% (16)	20.2% (20)
Child health	25.3% (19)	29.9% (32)	32.5% (27)	24.2% (24)
Don't recall	5.3% (4)	9.3% (10)	8.4% (7)	7.1% (7)
Other	20.0% (15)	2.8% (3)	4.8% (4)	14.1% (14)

Health providers (e.g., doctors, nurses, midwives) were most frequently mentioned as usual sources of health information (69 percent, n=312) followed by family members (29 percent, n=131), community health workers (CHWs) (26 percent, n=117), and friends (14 percent, n=63). Female IDP youth were significantly less likely than male IDP youth to rely on friends (9.3 percent versus 18.7 percent, p=0.004), but use of remaining information sources did not differ significantly by sex and marital status.

IDP youth were asked about receipt of information regarding health reasons for delaying marriage/ childbearing, child health and nutrition, and birth spacing/ FP in the past 12 months. We analyzed only unmarried youth for information on marriage delay; for cultural reasons, we limited analysis on FP to married IDP youth. For unmarried youth, significantly more female than male youth had received messages regarding marriage/childbearing delay (32.3 percent versus 15.6 percent, p<0.001). Among married youth, female youth were significantly more likely than male youth to receive FP messages (55.6 percent versus 23.0 percent, p<0.001); 11 married youth (10 of whom were female) declined to respond.

Overall, female youth were significantly more likely than male youth to receive child health information in the past year (45.0 percent versus 27.8 percent, p<0.001; there were 17 non-responders, of whom 15 were women. This difference was more pronounced for married than unmarried women (50.9 percent versus 38.4 percent), while married and unmarried men reported receiving child health information in similar proportions (27.9 percent and 27.7 percent, respectively).

Among youth receiving this information, we asked which sources for information on delaying marriage, child health, and FP were perceived as most convenient and most accurate (Figures 3.5, 3.6, and 3.7).

Figure 3.5. Most convenient and most accurate health information sources for delaying marriage among unmarried IDP youth receiving counseling for marriage delay, by sex (Afghanistan, 2017 (n=51)

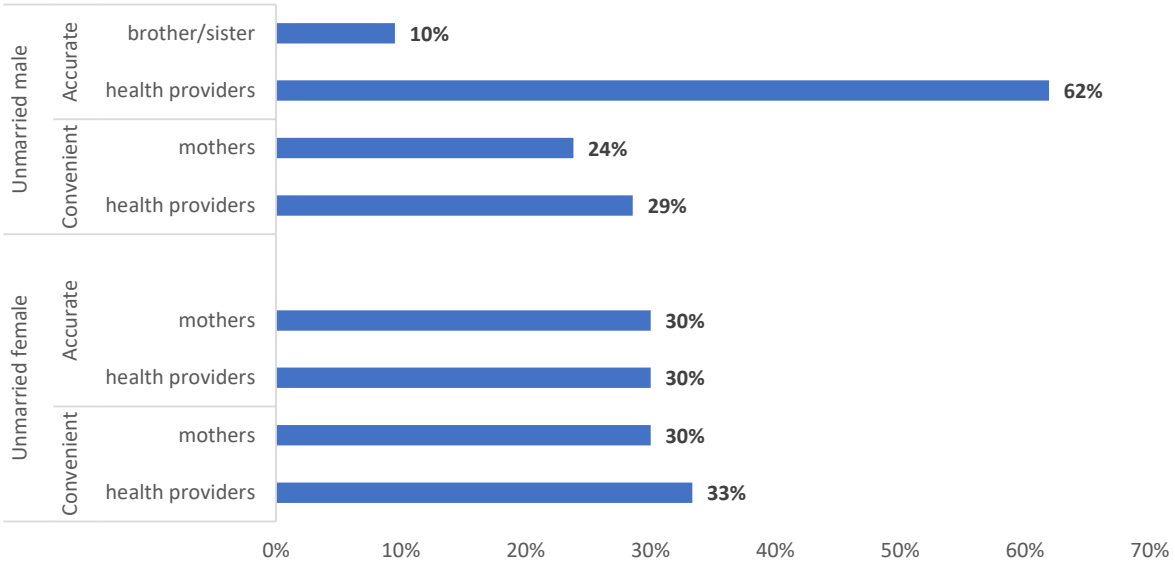
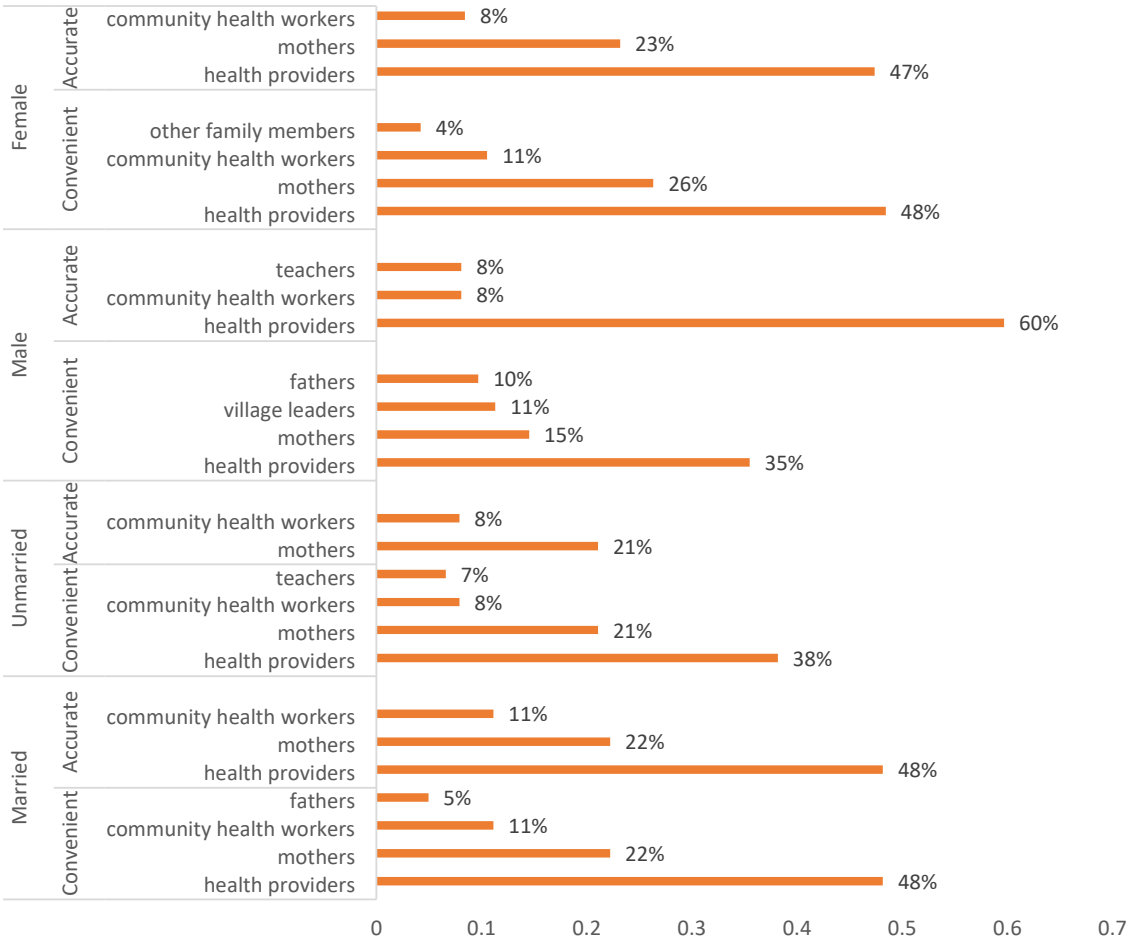
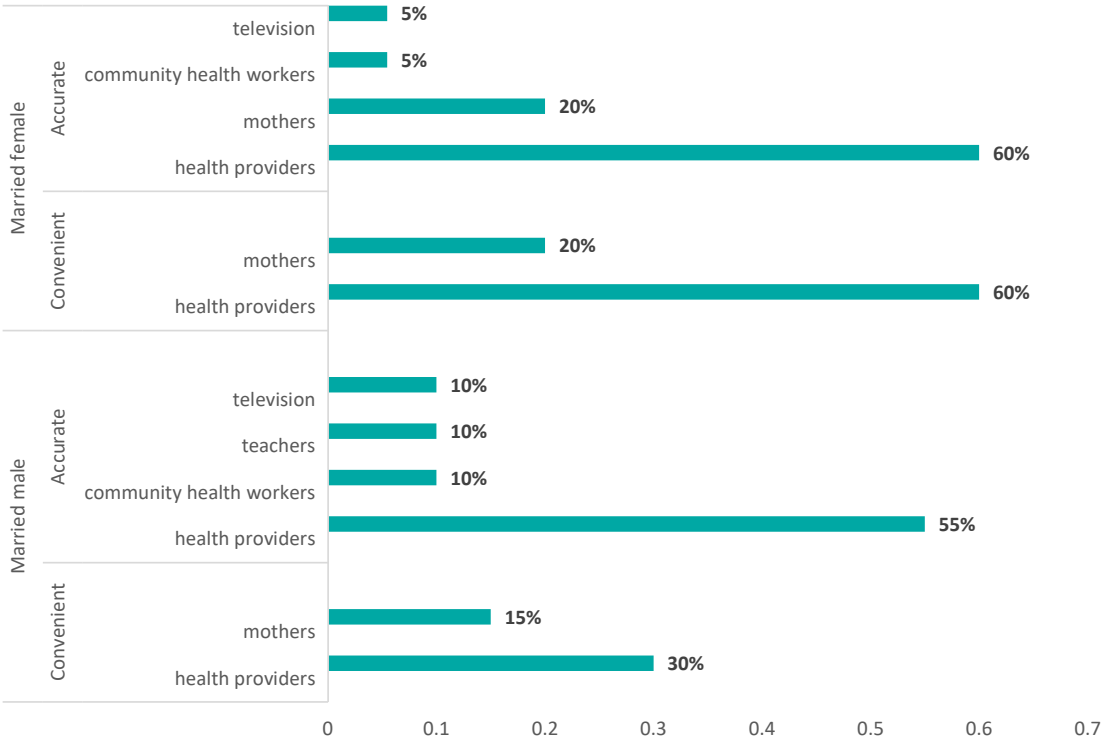


Figure 3.6. Most convenient and most accurate sources for child health information among IDP youth receiving counseling on child health, by sex and marital status (Afghanistan, 2017) (n=157)



Notably, for FP information, only 22.7 percent of married male and 46.2 percent of married female IDP youth reported having received any FP or birth spacing information in the past year.

Figure 3.7. Most convenient and most accurate family planning information among married IDP youth receiving health counseling, by sex (Afghanistan, 2017) (n=75)



Nearly all (94.7 percent) of the IDP youth indicated a desire for more health information; health maintenance (e.g., exercise/nutrition) was ranked highest, regardless of marital status or sex (56.7 percent to 58.0 percent of respondents). Other counseling areas prioritized by male youth were smoking cessation (34.1 percent) and accident prevention and best care for a newborn (19.4 percent each). Female youth prioritized depression and mental health issues (30.6 percent), stress reduction (25.9 percent), nutrition and feeding one's family (23.6 percent), and best newborn care practices (23.2 percent). Priority counseling areas also varied by marital status; married youth desired information about newborn health (23.4 percent) and smoking cessation (19.9 percent), while unmarried youth preferred information about depression and mental health issues (33.2 percent), nutrition and feeding one's family (27.4 percent), and stress reduction (26.6 percent). When asked about preferred channels for FP/RMNCH information, there was little variation by sex (57.4 percent for both male and female) or marital status (80.2 percent for married and 69.3 percent for unmarried) in preferring a health provider. More female than male IDP youth preferred television (25.9 percent versus 18.0 percent) or radio (30.6 percent versus 17.5 percent) as information sources, while male youth preferred home visits from CHWs (34.1 percent versus 11.1 percent). Print materials and call-in centers were named by 20 percent and 15 percent of male and female youth, respectively, while 15.6 percent of male and 8.3 percent of female youth preferred mobile phone voice messages. Home visits by CHWs were the second most preferred channel (34.8 percent for married and 27.1 percent for unmarried), and no other channel was preferred by more than 10 percent of respondents when analyzed by marital status.

Maternal and child health knowledge

Knowledge surrounding ANC, pregnancy risks/complications, and delivery risks/complications is presented in Table 3.7. We included unmarried IDP youth in this analysis, as about 50 percent of unmarried IDP youth of both sexes reported receiving RMNCH and nutrition information in the past six months. Most (80.0 percent) of the IDP youth correctly endorsed statements about the importance of ANC visits, but they were less knowledgeable regarding pregnancy and labor warning signs. Generally, female and married IDP youth had more knowledge than others regarding antenatal complications and actions women could take to ensure a healthy pregnancy.

Table 3.7. Knowledge of antenatal care, pregnancy complications, and risks among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Maternal Health Statement	Male (n=225)	Female (n=226)	Married (n=207)	Unmarried (n=244)
	% (n)	% (n)	% (n)	% (n)
Pregnant women should have ANC visits even if they feel well	78.2 (176)	81.9 (185)	87.0 (180)	74.2 (181)
Pregnant women should have at least four ANC visits	94.7 (213)	88.9 (201)*	97.1 (201)	87.3 (213)
Serious conditions that could be life-threatening during the antenatal period				
At least one condition identified (among those reporting at least one condition)	59.1 (133)	81.4 (184)	85.0 (176)	61.9 (151)
Bleeding	45.9 (61)	63.6 (117)	58.5 (103)	49.7 (75)
Severe headache	34.6 (46)	39.3 (79)	38.6 (68)	37.7 (57)
Severe weakness	31.6 (42)	25.4 (51)	26.1 (46)	31.1 (47)
Loss of consciousness	28.6 (38)	22.9 (46)	21.6 (38)	30.5 (46)
Severe abdominal pain	19.5 (26)	26.9 (54)	29.0 (51)	19.2 (29)
Swollen hands/face	17.3 (23)	25.4 (51)	24.4 (43)	20.5 (31)
Fever	21.1 (28)	20.9 (42)	18.2 (32)	25.2 (38)
Blurred vision	21.8 (29)	14.4 (29)	19.3 (34)	15.9 (24)
Convulsions	15.0 (20)	15.9 (32)	15.3 (27)	16.6 (25)
Difficulty breathing	18.8 (25)	10.9 (22)	14.8 (26)	13.9 (21)
Premature rupture of membranes	9.0 (12)	5.0 (10)	7.4 (13)	6.0 (9)
Reduced fetal movement	3.0 (4)	3.5 (7)	2.8 (5)	4.0 (6)
Other conditions	6.8 (9)	3.0 (6)	3.4 (6)	6.0 (9)
No response	3.1 (7)	6.6 (15)	0.5 (1)	8.6 (21)
Do not know	37.8 (8)	11.5 (26)	19.3 (40)	29.1 (71)
No conditions	0	0.04 (1)	0	4.0 (1)
What women can do to reduce health risks during pregnancy				
At least one action identified (among those reporting at least one action)	85.8 (193)	94.7 (214)	93.7 (194)	86.1 (210)
Regular ANC visits to midwife/doctor	72.0 (139)	87.4 (187)	80.4 (156)	81.0 (170)
Avoid inappropriate foods	40.9 (79)	23.4 (50)	27.3 (53)	36.2 (76)
Take traditional medicine	14.5 (28)	26.2 (56)	22.7 (44)	19.0 (40)
Consult with mother-in-law or mother	11.4 (22)	16.4 (35)	13.4 (26)	14.8 (31)
Consult a *dayee*	4.1 (8)	11.7 (25)	9.8 (19)	6.7 (14)
Consult a religious leader	7.8 (15)	1.9 (4)	6.7 (13)	2.9 (6)

Maternal Health Statement	Male (n=225)	Female (n=226)	Married (n=207)	Unmarried (n=244)
	% (n)	% (n)	% (n)	% (n)
Do not do heavy work	13.0 (25)	0.9 (2)	6.7 (13)	7.6 (16)
Do not know	13.8 (31)	3.5 (8)	4.8 (10)	11.5 (28)
Nothing	0.9 (2)	0.4 (1)	1.0 (2)	0.4 (1)
Conditions women younger than 18 years might be more likely to face during delivery				
At least one condition identified (among those reporting at least one condition)	62.7 (141)	64.6 (146)	71.5 (148)	57.0 (139)
Pre-eclampsia	56.0 (79)	63.0 (92)	54.1 (80)	65.5 (91)
Severe headache	53.9 (76)	51.4 (75)	54.1 (80)	51.1 (71)
Blurred vision	28.4 (40)	20.5 (30)	27.0 (40)	21.6 (30)
Convulsions	21.3 (30)	23.3 (34)	25.7 (38)	18.7 (26)
Swollen hands	22.7 (32)	32.9 (48)	30.4 (45)	25.2 (35)
Baby cannot pass through birth canal	41.1 (58)	36.3 (53)	39.2 (58)	38.1 (53)
Preterm labor/delivery	21.3 (30)	18.5 (27)	16.9 (25)	23.0 (32)
No answer	2.7 (6)	6.2 (14)	1.0 (2)	7.4 (18)
Do not know	34.7 (78)	29.2 (66)	27.5 (57)	35.7 (87)

Overall, 73.4 percent of IDP youth recognized that women could die from an obstetric complication, and 78.1 percent agreed pregnant women younger than 18 years were at greater risk of obstetric complications than their older counterparts. These responses differed somewhat by sex, as 79.7 percent and 80.1 percent of female youth and 67.1 percent and 76.0 percent of male youth agreed with these statements, respectively. The responses also differed by marital status, as 78.3 percent and 80.2 percent of married youth and 76.0 percent and 76.2 percent of unmarried youth agreed with these statements, respectively. Male youth were more likely to state not knowing an answer to these questions (24.4 percent and 9.8 percent, respectively) than female youth (14.6 percent and 5.8 percent, respectively). Unmarried youth were more likely to not know whether obstetric complications may lead to death (23.0 percent versus 15.5 percent of married youth), but not knowing whether young age at pregnancy was associated with greater complication risk did not differ by marital status (both 7.7 percent).

Nearly all (93 percent) IDP youth identified health facilities as the best place for a woman to deliver; this did not differ significantly by sex ($p=0.14$) or marital status ($p=0.51$). The most common reason for preferring facility-based delivery was perceived better standards of care, reported by 79 percent of IDP youth; male and unmarried youth were more likely to state this reason than female and married youth (91.7 percent versus 62.8 percent, $p<0.001$, and 81.2 percent versus 71.7 percent, $p=0.02$, respectively). Other reasons included safety (53 percent), with no significant differences by sex (56.6 percent for male versus 48.8 percent for female, $p=0.11$) or marital status (57.1 percent for married versus 48.9 percent for unmarried, $p=0.10$), and ease of access (33 percent). Male youth were more likely than female youth to report accessibility (40.5 percent versus 26.5 percent, $p=0.002$), but no significant difference was noted by marital status ($p=0.63$).

Knowledge of specific intrapartum complications and actions to plan for a safe delivery are summarized in Table 3.8. Similar to antepartum complications, female and married IDP youth were more likely to name specific complications. However, the groups were similar in the proportion who knew at least one action to plan for a safe delivery, though proportions varied somewhat by sex and marital status.

Table 3.8. Knowledge of intrapartum care and complications among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Maternal Health Statement	Male (n=225)	Female (n=226)	Married (n=207)	Unmarried (n=244)
	% (n)	% (n)	% (n)	% (n)
Potential Obstetric Complications during Labor and Delivery				
At least one complication identified (among those reporting at least one condition)	59.6 (134)	77.9 (176)	81.6 (169)	57.8 (141)
Severe bleeding	69.4 (93)	77.8 (137)	73.4 (124)	75.2 (106)
Loss of consciousness	39.6 (53)	44.3 (78)	44.4 (75)	39.7 (56)
High fever	37.3 (50)	31.3 (55)	29.6 (50)	39.0 (55)
Convulsions	28.4 (38)	37.5 (66)	32.5 (55)	34.8 (49)
Prolonged labor (>12 hours)	32.1 (43)	21.0 (37)	26.0 (44)	25.5 (36)
Baby in wrong position/malpresentation	30.6 (41)	9.1 (16)	17.2 (29)	19.9 (28)
Placenta not delivered within 30 minutes of birth	17.9 (24)	9.1 (16)	14.8 (25)	10.6 (15)
Other condition	6.7 (9)	7.4 (13)	9.5 (16)	4.3 (6)
No answer	4.0 (9)	9.7 (22)	1.9 (4)	11.1 (27)
Do not know	36.4 (82)	12.4 (28)	16.4 (34)	31.2 (76)
What Women and their Families Can Do to Prepare for Birth				
At least one action identified (among those reporting at least one action)	90.2 (203)	91.2 (206)	93.7 (194)	88.1 (215)
Go to health facility	85.7 (174)	85.0 (175)	85.6 (166)	85.1 (183)
Move temporarily to be closer to health facility	17.7 (36)	17.5 (36)	22.2 (43)	13.5 (29)
Identify mode of transport to health facility	29.1 (59)	11.2 (23)	16.5 (32)	23.3 (50)
Save money	28.6 (58)	33.0 (68)	29.4 (57)	32.1 (69)
Identify skilled provider	17.2 (35)	24.3 (50)	10.8 (21)	29.8 (64)
Identify blood donor	16.3 (33)	5.3 (11)	7.7 (15)	13.5 (29)
No answer	0.9 (2)	2.7 (6)	3.1 (6)	0.9 (2)
Don't know	8.9 (20)	6.2 (14)	3.6 (7)	1.6 (27)

Newborn care knowledge

IDP youth were asked a series of questions about newborn care, including appropriate umbilical cord care, best ways to regulate a newborn's body temperature, initiation and duration of breastfeeding, and when to begin complementary feeding (Table 3.9). We included all IDP youth in this analysis, regardless of marital status, due to reported exposure to child health information.

Table 3.9. Knowledge of newborn care, including appropriate cord care, newborn temperature regulation, and initiation of breastfeeding among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Newborn Health Statement	Male (n=225)	Female (n=226)	Married (n=207)	Unmarried (n=244)
	(n) %	(n) %	(n) %	(n) %
Appropriate cord care				
At least one action identified	74.7 (168)	94.2 (213)	90.8 (188)	79.9 (195)
Keep cord dry	36.3 (61)	57.7 (123)	54.3 (102)	42.1 (82)

Newborn Health Statement	Male (n=225)	Female (n=226)	Married (n=207)	Unmarried (n=244)
	(n) %	(n) %	(n) %	(n) %
Chlorhexidine daily for one week	35.1 (59)	16.4 (35)	27.1 (51)	22.1 (43)
Apply something else to the cord stump	23.8 (40)	25.4 (54)	19.1 (36)	29.7 (58)
Other action	4.8 (8)	0.5 (1)	3.2 (6)	1.5 (3)
Do not know	25.3 (57)	5.8 (13)	10.1 (21)	20.1 (49)
Best way to regulate newborn's body temperature				
At least one action identified	90.7 (204)	99.1 (224)	97.1 (201)	93.0 (227)
Wrap/swaddle the baby	77.9 (159)	73.7 (165)	77.6 (156)	74.0 (168)
Put hat on baby's head	40.7 (83)	63.8 (143)	47.8 (96)	57.3 (130)
Make sure room is warm	32.8 (67)	52.7 (118)	37.8 (76)	48.0 (109)
Keep baby wrapped on mother's chest	22.1 (45)	8.9 (20)	14.9 (30)	15.4 (35)
Delay bathing the baby	16.2 (33)	13.8 (31)	13.4 (27)	16.3 (37)
Do not know	9.3 (21)	0.9 (2)	2.9 (6)	7.0 (17)

Chlorhexidine (CHX) is a neonatal high-impact intervention (HII) to prevent neonatal umbilical infection that is relatively new to Afghanistan, with information being broadcast through mass media and provider channels. Male IDP youth had significantly more CHX knowledge than female IDP youth, but there was no difference by marital status (Table 3.10). We also analyzed associations between CHX knowledge and key variables segmented by sex and marital status and then conducted adjusted multivariable logistic regression analysis to determine independent associations with the most parsimonious model presented (Table 3.10). Generally, IDP youth in Kandahar had much higher levels of CHX knowledge, particularly among female participants, and this relationship was strengthened when adjusted for age. Mobile phone ownership was associated with CHX knowledge, particularly for married female IDP youth, and was more common for married than unmarried female youth.

Table 3.10. Correlates of knowledge of chlorhexidine use for umbilical cord care among IDP youth, by sex and marital status (Afghanistan, 2017) (n=447)

Variable	Male (n=225)	AOR (95% CI)†	Female (n=227)	AOR (95% CI)	Married (n=207)	AOR (95% CI)†	Unmarried (n=244)	AOR (95% CI)†
Overall %	26.2**	---	15.4	---	20.8%	---	20.9%	---
Age, mean±SD	21.2± 3.1 vs. 21.0± 3.3		21.9± 2.6 vs. 21.8± 3.1		23.3± 2.0 vs. 23.2± 2.5		19.9± 2.6 vs. 19.8± 3.0	
Province	***		***		***		***	
Kandahar	46.7	3.37 (1.42–7.98)	29.3	7.96 (2.14–29.6)	75.0	10.7 (4.03–28.2)	32.2	12.6 (2.80–56.9)
Nangarhar	14.7	0.89 (0.35–2.29)	13.0	2.86 (0.69–11.9)	13.0	1.04 (0.38–2.85)	14.6	4.33 (0.91–20.5)
Takhar	17.3	Ref	4.0	Ref	13.6	Ref	3.5	Ref
Any formal education	26.2 vs. 26.3		5.0 vs. 17.7*		22.6 vs. 20.0		21.1 vs. 20.7	

Variable	Male (n=225)	AOR (95% CI)†	Female (n=227)	AOR (95% CI)	Married (n=207)	AOR (95% CI)†	Unmarried (n=244)	AOR (95% CI)†
Has own mobile phone	25.6 vs. 50.0		20.5 vs. 8.6*	3.16 (1.31–7.61)	24.0 vs. 8.2*	3.21 (1.00–10.4)	23.7 vs. 12.9	
Prior Internet use	42.1 vs. 20.8**		10.0 vs. 15.7		47.4 vs. 18.1**		33.0 vs. 17.9*	
View television at least weekly	47.0 vs. 17.6***	2.72 (1.37–5.41)	21.3 vs. 13.6		43.2 vs. 14.7***		29.1 vs. 16.4*	
Listen to radio at least weekly	24.4 vs. 28.4		27.3 vs. 10.6**	2.35 (1.00–5.51)	31.0 vs. 16.8*		22.9 vs. 18.6	
See health provider in past 6 months	31.3 vs. 23.2		16.8 vs. 13.7		25.2 vs. 16.3		19.8 vs. 21.8	

*p<0.05; **p<0.01; ***p<0.001; †analysis adjusted by age.

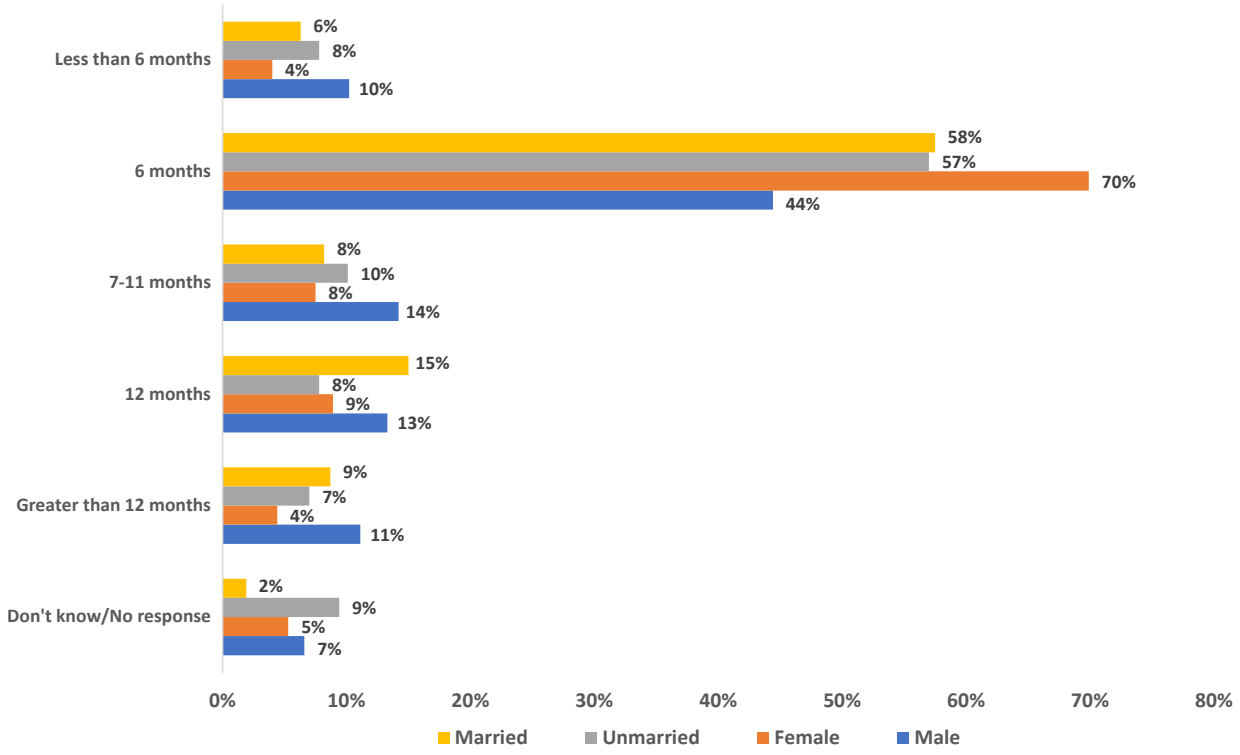
We also assessed knowledge surrounding early initiation and duration for both exclusive and complementary breastfeeding. Female IDP youth were more likely than male IDP youth to know that breastfeeding should be initiated within one hour of birth (p<0.001), while there was no significant difference by marital status (Table 3.11). IDP youth from Nangarhar and Kandahar were also more likely to identify the correct time to initiate breastfeeding (74.8 percent and 69.3 percent in Nangarhar and Kandahar, respectively, compared with 48.7 percent in Takhar). For IDP youth overall, having sought health care from a provider in the past six months was also associated with correct knowledge regarding breastfeeding initiation (71.5 percent versus 58.3 percent, p<0.01). The association between sex and correct knowledge of timing for early breastfeeding remained significant (AOR=2.17, 95 percent CI: 1.43–3.31) in analysis adjusted by age, marital status, province, and having seen a health provider in the past six months.

Table 3.11. Knowledge of early breastfeeding initiation among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

When to Initiate Breastfeeding	Male (n=225)	Female (n=226)	Married (n=207)	Unmarried (n=244)
	% (n)	% (n)	% (n)	% (n)
Within one hour of birth	54.2 (122)	74.3 (168)	67.2 (139)	61.9 (151)
Within several hours of birth	18.7 (42)	16.4 (37)	18.4 (38)	16.8 (41)
Within one day	7.1 (16)	2.7 (6)	3.9 (8)	5.7 (14)
Within several days	3.1 (7)	1.3 (3)	2.4 (5)	2.1 (5)
When the white milk comes in	6.7 (15)	2.7 (6)	4.4 (9)	4.9 (12)
Do not know	10.2 (23)	2.7 (6)	3.9 (8)	(21)

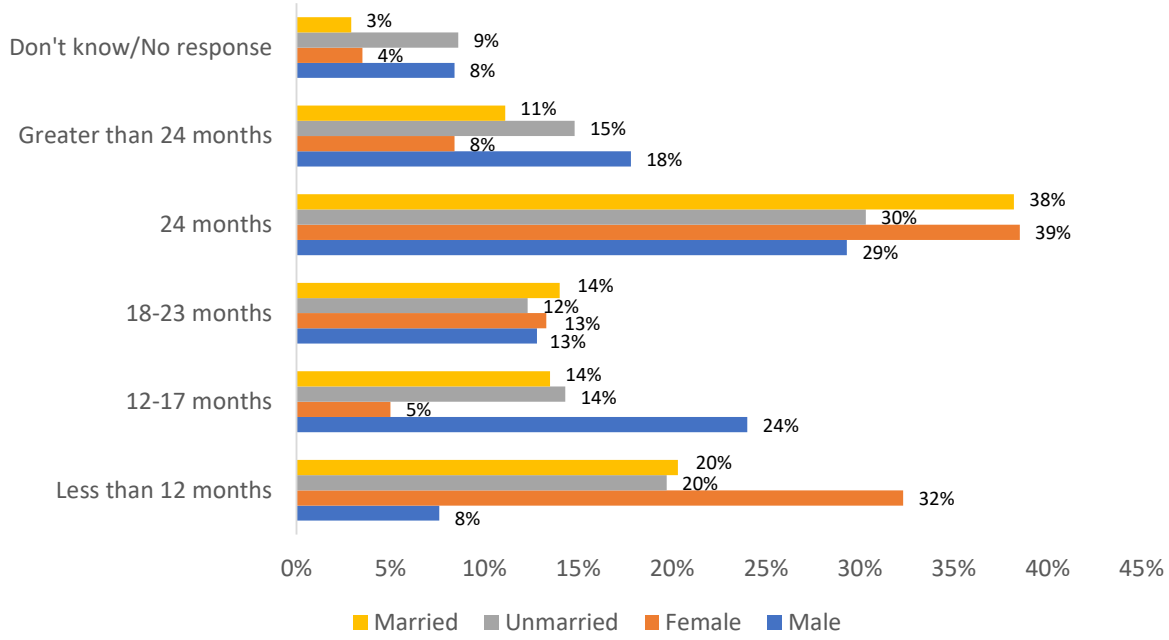
For exclusive breastfeeding practices, nearly all (94.5 percent) IDP youth stated that breast milk alone was the best thing to feed an infant under six months of age; female (97.3 percent versus 91.6 percent for male, p<0.01) and married (97.1 percent versus 92.2 percent for unmarried, p=0.02) IDP youth were more likely to respond correctly. When respondents needed to specify the number of months an infant should be exclusively breastfed, female respondents were most likely to state the correct response of six months; knowledge levels did not differ by marital status (Figure 3.8).

Figure 3.8. Knowledge of exclusive breastfeeding duration (in months) among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)



Regarding the duration of complementary feeding (i.e., supplemental foods with continued breastfeeding), female and married IDP youth were most likely to provide the correct response of 24 months (Figure 3.9). However, a substantial proportion of female youth thought breastfeeding should end before 12 months.

Figure 3.9. Knowledge of complementary breastfeeding duration (in months) among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

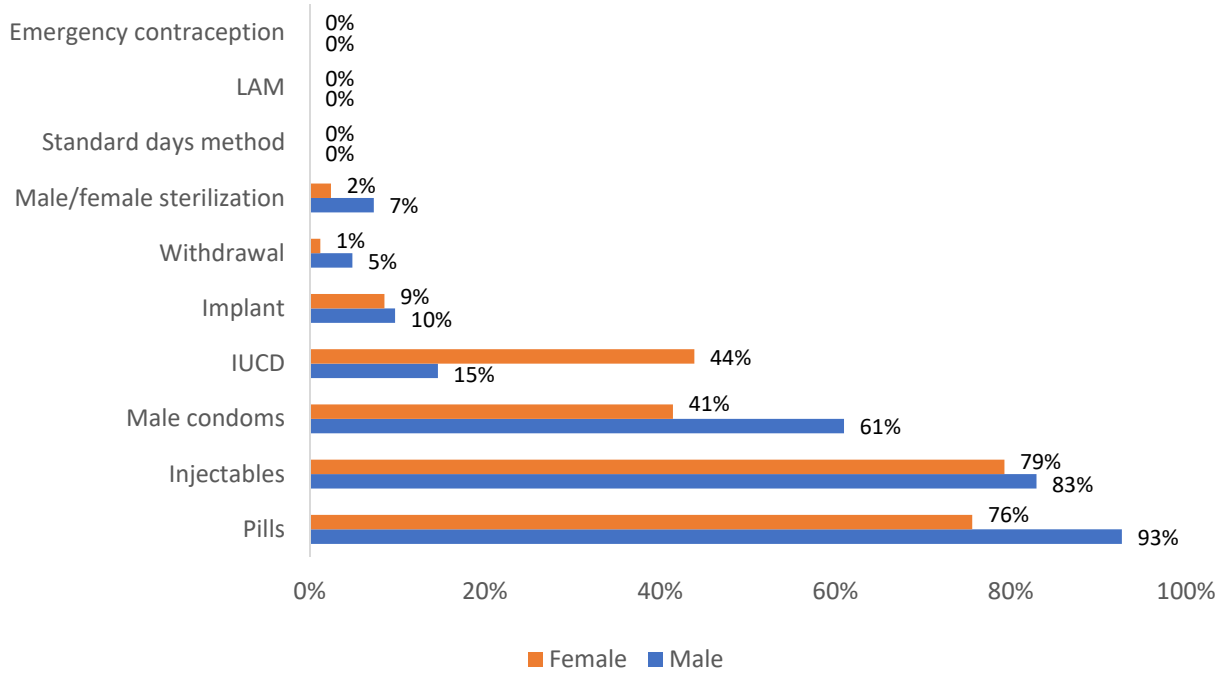


Family planning knowledge

We included only married IDP youth for FP and birth spacing knowledge questions due to cultural sensitivities surrounding this topic before marriage. Among married youth, female youth were more likely than male youth to be aware of changes in fertility during different phases of the menstrual cycle (56.3 percent, n=67/119 versus 30.7 percent, n=27/88). Of those aware, 45.2 percent (30 female and 12 male) correctly identified the time just after menses finished, and 18.3 percent (12 female and 5 male) identified midway between menstrual periods, as the peak fertility times. Fifty-nine percent of married IDP youth had heard of birth spacing methods; this awareness was significantly more likely for female than male youth (68.9 percent versus 46.6 percent, p=0.003).

When asked to name specific FP methods, married IDP youth who were aware of FP predominantly listed condoms, oral contraceptive pills, and injectable hormonal methods (Figure 3.10). No participants spontaneously mentioned the lactational amenorrhea method (LAM), emergency contraception, or natural FP/Standard Days Method.

Figure 3.10. Awareness of family planning methods among married IDP youth, by sex (Afghanistan, 2017) (n=123)



Knowledge surrounding specific methods was also relatively low. Few married IDP youth could correctly identify the length of time exclusive breastfeeding is effective for preventing pregnancy: only 13.5 percent (n=28) responded six months, and this knowledge was much more common among male than female youth (23.9 percent versus 5.9 percent, p<0.001). Nearly half (47.8 percent) of married male youth and 11.7 percent of married female youth did not know the duration of pregnancy prevention with lactation. Among IDP youth, those who had ever attended school were significantly more likely to respond correctly with regard to LAM duration (25.8 percent versus 11.0 percent, p=0.11). Married IDP youth in Kandahar were the most likely to have correct knowledge of LAM (40.0 percent in Kandahar versus 11.6 percent in Nangarhar and 5.8 percent in Takhar, p<0.001). Age and income were not predictive of correct LAM knowledge among married IDP youth.

FP knowledge questions often received a response of "do not know." The four statements measuring FP knowledge shown in Table 3.12 each had at least 15 percent of the youth responding "do not know," with a high of 41.8 percent for the intrauterine contraceptive device (IUCD) question.

Table 3.12. Agreement with family planning statements among married IDP youth (Afghanistan, 2017) (n=207)

Family Planning Knowledge Statement	Yes % (n)	No % (n)	Do Not Know % (n)
Withdrawal is a highly effective method for preventing pregnancy.			
Married male IDP youth (n=88)	29.5 (26)	36.4 (32)	34.1 (30)
Married female IDP youth (n=119)	38.7 (46)	4.2 (5)	57.1 (68)
Young women should not use family planning methods because it may create problems getting pregnant later.			
Married male IDP youth (n=88)	37.5 (33)	33.0 (29)	29.5 (26)
Married female IDP youth (n=119)	52.1 (62)	24.4 (29)	23.5 (28)
The intrauterine contraceptive device or loop can prevent pregnancy for up to 10 years.			
Married male IDP youth (n=88)	18.2 (16)	35.2 (31)	46.6 (41)
Married female IDP youth (n=119)	37.8 (45)	19.3 (23)	42.9 (51)
Irregular periods or bleeding between periods while using the injection or implant will usually resolve on its own.			
Married male IDP youth (n=88)	19.3 (17)	28.4 (25)	52.3 (46)
Married female IDP youth (n=119)	40.3 (48)	19.3 (23)	40.3 (48)

For all FP questions, lack of knowledge was common among both sexes. Male youth were more likely than female youth to disagree with false statements regarding efficacy of withdrawal and risk of infertility associated with hormonal contraceptive use. Female participants were more likely than male participants to agree with correct statements about duration of IUCD efficacy and resolution of irregular bleeding with hormonal contraception. There were no differences by province in the proportion of married IDP youth with correct knowledge regarding withdrawal efficacy or risk of sterility, but youth from Kandahar and Nangarhar were more likely to know about resolution of dysfunctional bleeding with hormonal contraception than peers from Takhar (42.9 percent and 50.7 percent versus 14.6 percent, respectively, $p<0.001$), and knowledge of IUCD duration was higher among those from Nangarhar than those from Kandahar and Takhar (42.0 percent versus 25.7 percent and 22.3 percent, respectively, $p<0.001$). Correct knowledge did not differ significantly between married IDP youth with and without any formal education, except that youth with any formal education were less likely to have correct knowledge about IUCD duration (19.7 percent versus 34.3 percent, $p=0.04$).

Care utilization and sources of information

Half (55.2 percent) of IDP youth reported seeking care at a health facility in the past three months, with female youth significantly more likely than male youth to do so (67.9 percent versus 43.5 percent, $p<0.001$). Care seeking was also more likely among IDPs reporting displacement within their home province (69.2 percent versus 45.2 percent, $p<0.001$), those reporting higher monthly income (13115 Afs versus 9975 Afs, $p=0.05$), those reporting no formal education (60.1 percent versus 49.5 percent, $p=0.03$), and those from Kandahar Province (69.8 percent in Kandahar versus 55.7 percent in Nangarhar and 41.6 percent in Takhar; $p<0.001$). Table 3.13 presents sociodemographic variables associated with seeking care at a facility in the past three months.

We queried usual sources for both general health and RMNCH information. Most IDP youth stated that doctors or midwives (64.5 percent), followed by their mothers (35.9 percent), fathers (23.1 percent), and

siblings (9.3 percent), were the usual sources of general health information. There were few differences by sex, except that male youth were significantly more likely than female youth to consult their fathers for general health information (35.1 percent versus 11.1 percent, p<0.001). Unmarried IDP youth were somewhat more likely than married youth to consult their mothers (39.8 percent versus 31.4 percent, p=0.07), but there were no other differences by marital status.

Usual sources of RMNCH information mirrored those for general health: doctors and midwives (57.2 percent) were the most frequently reported, followed by mothers (27.3 percent), fathers (18.6 percent), and siblings (8.9 percent). Male youth were significantly more likely than female youth to consult their fathers (26.7 percent versus 10.6 percent, p<0.001) and female youth significantly more likely than male youth to consult their mothers (32.3 percent versus 22.2 percent, p=0.02); other sources did not differ significantly by sex. None of the named sources differed by marital status; we did not specifically ask about spouse as an information source, but "other family member,"which could represent a spouse, was named by 27.5 percent of married IDP youth (as compared with 8.2 percent of unmarried youth, p<0.001).

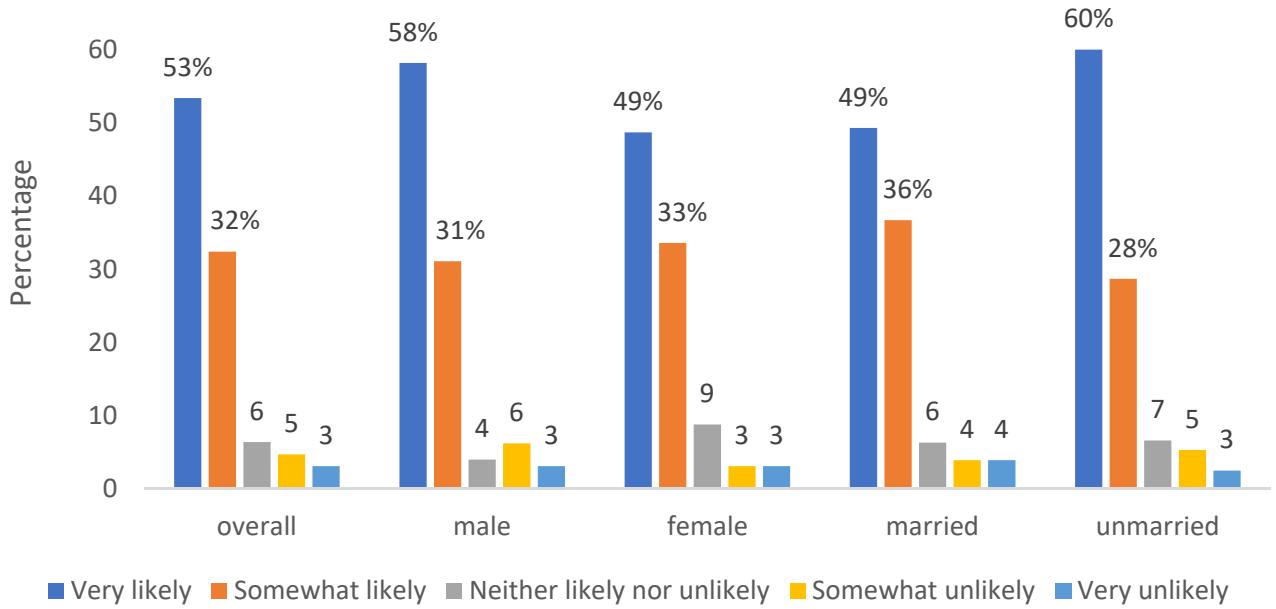
Table 3.13. Associations between key variables and health care-seeking behavior in the past three months among IDP youth (Afghanistan, 2017) (n=451)

Sociodemographic Variable	OR (95% CI)
Sex	
Male	Reference
Female	4.1 (2.2, 7.5) ***
Marital Status	
Unmarried	Reference
Married	1.05 (0.72, 1.52)
Internal IDP	
No	Reference
Yes	1.7 (1.0, 3.0)
Region	
Nangarhar	Reference
Kandahar	0.4 (0.2, 0.7) **
Takhar	0.3 (0.1, 0.6) **
Income (quintile)	
Lowest	Reference
Second	1.6 (0.7, 3.6) *
Middle	2.2 (1.0, 4.7)
Fourth	2.7 (0.8, 8.7)
Highest	1.3 (0.6, 3.1)

*p<0.05. ** p<0.01. *** p<0.001.
CI=confidence interval; n=number; OR=odds ratio

Most (86 percent) IDP youth agreed they would be likely to use a free mobile phone-based service for RH information. The likelihood of using a mobile phone service was somewhat lower for female than male IDP youth and did not vary significantly by marital status (Figure 3.11).

Figure 3.11. Likelihood of using a free mobile phone-based service for reproductive health information among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)



The likelihood of IDP youth using this service also was not associated with income level, visiting a health facility in the past six months, displacement within birth province, or age; however, owning a mobile phone increased the likelihood of program use (89.1 percent with a phone versus 77.5 percent without, p=0.002). Most IDP youth would prefer to speak to a live person in a mobile phone program (76.7 percent), while 18.4 percent stated a preference for a recorded message. Married (80.7 percent versus 73.4 percent for unmarried, p=0.07) and female (82.3 percent versus 71.1 percent for male, p=0.005) participants were more likely to prefer a live call-in service. We did not query written/text message delivery due to low literacy rates.

Family decision making, marital status, and marriage attitudes

Nearly half of IDP respondents were married (45.9 percent), and female IDP participants were more likely to be married and to have married at a younger age. Of married participants, 43.5 percent had known their spouse for at least one year prior to marriage; nearly one-third indicated that they had met their spouses for the first time on the wedding day. Among unmarried participants, 15.6 percent reported being engaged; the median age of engagement was 17.5 years. Of married or engaged participants (n=245), most (71.8 percent) reported that their family or their spouse's family chose their marriage partners, while 21.2 percent reported that they chose their spouse. Of those whose families chose, 63.1 percent who responded to this question reported being asked by their family whether they were willing to proceed with the arrangement. Female

IDP youth were less likely than male IDP youth to have this choice (24.0 percent versus 33.7 percent); 13/101 female youth elected not to respond to this question, while no male youth did.

Attitudes regarding gender equity and norms within marital relationships were gauged for IDP youth, with level of agreement differing substantially by sex and marital status (Table 3.14).

Table 3.14. Level of agreement or uncertainty regarding gender equity and norms within marriage among IDP youth, by sex and marital status. (Afghanistan 2017) (number variable; proportion disagreeing or declining to respond not shown)

Attitude Statement	Sex				Marital Status			
	Male % Agree	Female % Agree	Male % Do not know	Female % Do not know	Married % Agree	Unmarried % Agree	Married % Do not know	Unmarried % Do not know
Husband is justified to beat wife if she goes out without telling him.	52 (n=117)	52.7 (n=119)	0.0 (n=0)	1.8 (n=4)	62.3 (n=129)	43.9 (n=107)	0.5 (n=1)	1.2 (n=3)
Husband is justified to beat wife if she neglects the children.	30.7 (n=69)	55.8 (n=126)	0.0 (n=0)	1.8 (n=4)	50.7 (n=105)	36.9 (n=90)	0.5 (n=1)	1.2 (n=3)
Husband is justified to beat wife if she argues with him.	31.6 (n=71)	58.4 (n=132)	0.9 (n=2)	3.1 (n=7)	51.7 (n=107)	39.3 (n=96)	1.4 (n=3)	2.5 (n=6)
Husband is justified to beat wife if she burns the food.	16.9 (n=38)	33.2 (n=75)	2.2 (n=5)	0.9 (n=2)	30.0 (n=62)	20.9 (n=51)	1.9 (n=4)	1.2 (n=3)
Husband is justified to beat wife if she refuses to have sex with him.	25.8 (n=58)	39.8 (n=90)	6.7 (n=15)	14.6 (n=33)	40.1 (n=83)	26.6 (n=65)	2.9 (n=6)	17.2 (n=42)
Contraception is a woman's business and a man should not have to worry about it.	24.4 (n=55)	28.3 (n=64)	19.6 (n=44)	29.2 (n=66)	32.9 (n=68)	20.9 (n=51)	19.8 (n=41)	28.3 (n=69)
Women who use contraception may become promiscuous.	24.9 (n=56)	35.0 (n=79)	30.2 (n=68)	42.9 (n=97)	33.8 (n=70)	26.6 (n=65)	28.5 (n=59)	43.4 (n=106)

With respect to differences in marital attitudes (Table 3.15), a higher proportion of female than male participants agreed that the ideal age of marriage is before 24 years. This question may have been problematic, as some male participants appeared to agree that both marrying before and after 24 years was preferable; it is unclear if some changed their minds after hearing the second statement. Similarly, there were inconsistencies in whether parents should choose their children's spouses or whether young people should choose for themselves. A slightly higher proportion of female than male IDP youth agreed that women should select their spouses (90.3 percent versus 83.1 percent).

Table 3.15. Levels of agreement with statements about marriage among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Statement	Sex						Marital Status					
	Male			Female			Married			Unmarried		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
It is better marrying at age 16 than at age 24 years.	40.4% (91)	8.0% (18)	51.6% (116)	11.5% (26)	10.2% (23)	78.3% (177)	26.1% (54)	5.8% (12)	68.1% (141)	25.8% (63)	11.9% (30)	62.3% (152)
Marriage should be before first menstruation.	24.0% (54)	22.7% (51)	53.3% (120)	10.2% (23)	6.6% (15)	83.2% (188)	15.9% (33)	17.4% (36)	66.7% (138)	18.0% (44)	12.3% (30)	69.7% (170)
The ideal age at marriage is less than 24 years old.	55.1% (124)	16.0% (36)	28.9% (65)	69.5% (157)	17.3% (39)	13.3% (30)	65.7% (136)	15.9% (33)	18.4% (38)	59.4% (145)	17.2% (42)	23.4% (57)
The ideal age at marriage is more than 24 years old.	58.2% (131)	16.0% (36)	25.8% (58)	46.0% (104)	35.0% (79)	19.0% (43)	58.9% (122)	19.8% (41)	21.3% (44)	46.3% (113)	30.3% (74)	39.6% (57)
Women should control when they marry.	59.1% (133)	13.8% (31)	27.1% (61)	41.6% (94)	15.0% (34)	43.4% (98)	58.0% (120)	16.9% (35)	25.1% (52)	43.9% (107)	12.3% (30)	43.9% (107)
Men should control when they marry.	83.1% (187)	10.7% (24)	6.2% (14)	90.3% (204)	8.4% (19)	1.3% (3)	87.9% (182)	7.2% (15)	4.8% (10)	85.7% (209)	11.5% (28)	2.9% (7)
It is better for young people to choose whom they marry.	82.7% (186)	8.0% (18)	9.3% (21)	73.9% (167)	17.7% (40)	8.4% (19)	87.0% (180)	7.7% (16)	5.3% (11)	70.9% (173)	17.2% (42)	11.9% (29)
It is better for parents to choose whom their children marry.	70.7% (159)	14.2% (32)	15.0% (34)	58.4% (132)	18.6% (42)	23.0 (52)	60.4% (125)	18.4% (38)	21.3% (44)	68.0% (166)	14.8% (36)	17.2% (42)
Parental consent (for marrying) is required.	81.8% (184)	11.1% (25)	7.1% (16)	90.3% (204)	7.5% (17)	2.2% (5)	85.0% (176)	10.6% (22)	4.3% (9)	86.9% (212)	8.2% (20)	4.9% (12)
Parents should have a young person's consent as a requirement before marrying.	86.7% (195)	7.1% (16)	6.2% (14)	96.5% (218)	3.1% (7)	0.4% (1)	92.3% (191)	5.3% (11)	2.4% (5)	91.0% (222)	4.9% (12)	4.1% (10)
Love marriage is good.	64.4% (145)	18.7% (42)	16.9% (38)	57.1% (129)	22.1% (50)	20.8% (47)	72.9% (151)	13.0% (27)	14.0% (29)	50.4% (123)	26.6% (65)	23.0% (56)
It is better to know your future husband/wife before you marry.	79.1% (178)	15.1% (34)	5.8% (13)	77.0% (174)	18.9% (42)	4.3% (10)	85.0% (176)	11.1% (23)	3.9% (8)	72.1% (176)	21.7% (53)	7.4% (15)

Statement	Sex						Marital Status					
	Male			Female			Married			Unmarried		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
It is acceptable to meet him/her on the day of the wedding.	50.7% (114)	16.4% (37)	32.9% (74)	37.2% (84)	13.3% (30)	59.5% (112)	42.0% (87)	14.5% (30)	43.5% (90)	45.5% (111)	15.2% (37)	39.3% (96)

Table 3.16 provides levels of agreement with perceived community social norms surrounding FP/MNCH among IDP youth. Overall, higher proportions of male than female participants endorsed statements regarding community norms supporting FP and ANC use by women in the community. Further, higher percentages of male than female participants believed that FP or ANC use was normative and that women and men in their communities went to health facilities to discuss FP with providers; these trends were similar among married and unmarried IDP youth.

Table 3.16. Perceived social norms concerning maternal, newborn, and child health and family planning among IDP youth, by sex and marital status (Afghanistan, 2017) (n=451)

Statement	Sex						Marital Status					
	Male			Female			Married			Unmarried		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
Husbands and wives in my community use family planning to space births.	72.4% (163)	15.1% (34)	12.4% (28)	41.2% (93)	30.5% (69)	28.3% (64)	62.3% (129)	21.7% (45)	15.9% (33)	52.1% (127)	23.8% (58)	24.2% (59)
Women in my community get care for their pregnancies from health providers before delivery.	75.6% (170)	14.7% (33)	9.8% (22)	54.0% (122)	19.0% (43)	27.0% (61)	63.8% (132)	13.5% (28)	13.0% (27)	57.4% (140)	19.7% (48)	23.0% (56)
Women in my community give birth at health facilities.	83.6% (188)	5.8% (13)	10.7% (24)	78.3% (177)	8.9% (20)	12.8% (29)	80.2% (166)	7.7% (16)	12.1% (25)	81.6% (199)	0.7% (17)	11.5% (28)
Women in my community go to health facilities/talk to health workers about family planning methods.	68.9% (155)	17.8% (40)	13.3% (30)	54.4% (123)	13.7% (31)	31.9% (72)	66.7% (138)	14.5% (30)	18.8% (39)	57.4% (140)	16.8% (41)	25.8% (63)
Men in my community go to health facilities/talk to health workers about family planning methods.	74.7% (168)	14.7% (33)	10.7% (24)	42.0% (95)	17.3% (39)	40.7% (92)	64.7% (134)	14.5% (30)	20.8% (43)	52.9% (129)	17.2% (42)	29.9% (73)

Statement	Sex						Marital Status					
	Male			Female			Married			Unmarried		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
Men in my community go to health facilities/talk to health workers about antenatal care and birth planning.	70.2% (158)	19.6% (44)	10.2% (23)	44.3% (100)	19.5% (44)	36.3% (82)	65.7% (136)	17.4% (36)	16.9% (35)	50.0% (122)	21.3% (52)	28.7% (70)
People in my community are supportive of family planning use.	56.9% (157)	14.7% (33)	15.6% (35)	43.8% (99)	30.5% (69)	25.7% (58)	61.8% (128)	20.3% (42)	17.9% (37)	52.5% (128)	24.6% (60)	23.0% (56)
People in my community are supportive of delivering in a health facility.	76.4% (172)	16.0% (36)	7.6% (17)	73.0% (165)	15.0% (34)	12.0% (27)	74.4% (154)	15.5% (32)	10.1% (21)	75.0% (183)	15.6% (38)	9.4% (23)
Men in my community are involved in family planning.	70.7% (159)	19.1% (43)	10.2% (23)	42.9% (97)	31.0% (70)	26.1% (59)	59.4% (123)	22.7% (47)	17.9% (37)	54.5% (133)	27.1% (66)	18.4% (45)
Men in my community are involved in birth preparedness planning.	71.6% (161)	19.1% (43)	9.3% (21)	51.8% (117)	28.3% (64)	19.9% (45)	68.1% (141)	20.3% (42)	11.6% (24)	56.1% (137)	26.6% (65)	17.2% (42)
I believe that frequent childbearing with short spacing between births is harmful to the health of the mother.	75.6% (170)	14.2% (32)	10.2% (23)	80.1% (181)	4.0% (9)	15.9% (36)	75.8% (157)	7.7% (16)	16.4% (34)	79.5% (194)	10.2% (25)	10.2% (25)
I believe that early (before age 18) childbearing is harmful to the health of the mother.	76.0% (171)	17.3% (39)	6.7% (15)	73.9% (167)	9.7% (22)	16.4% (37)	72.5% (150)	11.6% (24)	15.9% (33)	77.0% (188)	15.2% (37)	7.8% (19)
I believe that using family planning methods to space children is safe.	75.1% (169)	14.2% (32)	10.7% (24)	83.2% (188)	8.9% (20)	8.0% (18)	81.6% (169)	9.2% (19)	9.2% (19)	77.0% (188)	13.5% (33)	9.4% (23)
Most family planning methods can be removed/ stopped any time you want to get pregnant.	49.8% (112)	34.7% (78)	15.6% (35)	47.4% (107)	46.0% (104)	6.6% (15)	54.1% (112)	38.2% (79)	7.7% (16)	43.9% (107)	42.2% (103)	13.9% (34)

Statement	Sex						Marital Status					
	Male			Female			Married			Unmarried		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
Going to at least four ANC visits can help women have healthier babies.	82.2% (185)	10.7% (24)	7.1% (16)	90.3% (204)	8.9% (20)	0.9% (2)	90.8% (188)	6.8% (14)	2.4% (5)	82.4% (201)	12.3% (30)	5.3% (13)
Families are more prepared for having babies if husbands are involved in their wives' family planning use.	72.0% (162)	20.4% (46)	7.6% (17)	61.5% (139)	32.3% (73)	6.2% (14)	74.4% (154)	18.8% (39)	6.8% (14)	60.2% (147)	32.8% (80)	7.0% (17)
If a woman experiences complications during delivery, she is more likely to get the help she needs at a health facility than if she gives birth at home.	73.8% (166)	15.1% (34)	11.1% (25)	88.5% (200)	9.3% (21)	2.2% (5)	89.4% (185)	8.7% (18)	6.8% (14)	78.3% (191)	15.2% (37)	6.6% (16)
Families are more likely to have healthy babies and mothers if husbands are involved in their wives' birth preparedness planning.	77.8% (175)	15.6% (35)	6.7% (15)	90.3% (204)	7.1% (16)	2.7% (6)	87.0% (180)	8.7% (18)	4.3% (9)	81.6% (199)	13.5% (33)	4.9% (12)
Families who use family planning to space their pregnancies have a better future than families who do not use family planning.	68.0% (153)	19.1% (43)	12.9% (29)	76.6% (173)	13.7% (31)	9.7% (22)	72.9% (151)	13.5% (28)	13.5% (28)	71.7% (175)	18.9% (46)	9.4% (23)
It is difficult for women to get family planning methods.	40.4% (91)	22.7% (51)	36.9% (83)	41.6% (94)	28.8% (65)	29.6% (67)	48.3% (100)	21.3% (44)	30.4% (63)	34.8% (85)	29.5% (72)	35.7% (87)
It is difficult for women to go to at least four antenatal visits during pregnancy.	43.1% (97)	13.8% (31)	43.1% (97)	47.4% (107)	20.4% (46)	32.3% (73)	54.1% (112)	10.1% (21)	35.7% (74)	37.7% (92)	23.0% (56)	39.3% (96)

Statement	Sex						Marital Status					
	Male			Female			Married			Unmarried		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
It is difficult for pregnant women to access healthy foods.	43.1% (97)	16.9% (38)	40.0% (90)	44.3% (100)	27.4% (62)	28.3% (64)	51.2% (106)	12.1% (25)	36.7% (76)	37.3% (91)	30.7% (75)	32.0% (78)
It is difficult for women to be able to give birth in health facilities.	28.9% (65)	17.8% (40)	53.3% (120)	51.3% (116)	23.0% (52)	25.6% (58)	46.9% (97)	15.5% (32)	37.7% (78)	34.4% (84)	24.6% (60)	41.0% (100)
It is difficult for infants to get care in health facilities.	34.7% (78)	16.9% (38)	48.5% (109)	44.7% (101)	30.5% (69)	24.8% (56)	48.3% (100)	16.4% (34)	35.3% (73)	32.4% (79)	29.9% (73)	37.7% (92)
My community wouldn't think it is appropriate for husbands to be involved in their wives' use of family planning methods.	37.3% (84)	30.2% (68)	32.4% (73)	37.2% (84)	35.0% (79)	27.9% (73)	41.5% (86)	32.4% (67)	26.1% (54)	33.6% (82)	32.8% (80)	33.6% (82)
My community wouldn't think it is appropriate for husbands to be involved in their wives' pregnancies.	37.3% (84)	20.4% (46)	42.2% (95)	38.9% (88)	24.8% (56)	36.3% (82)	42.5% (88)	25.6% (53)	31.9% (66)	34.4% (84)	20.1% (49)	45.5% (111)

School-based Youth

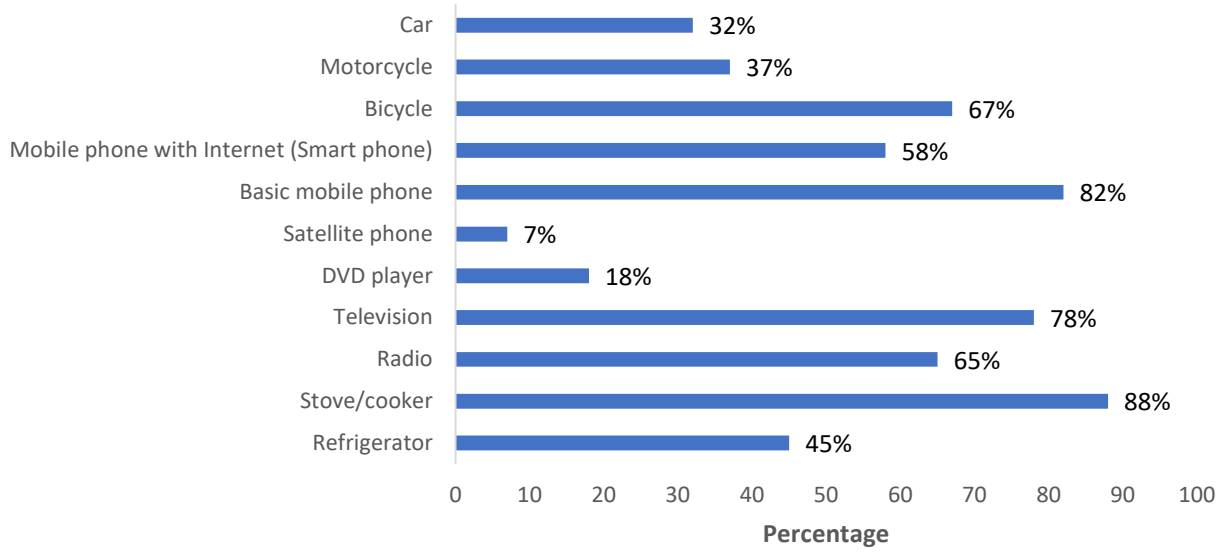
A total of 1,200 school-based (secondary and post-secondary) youth ages 15–25 years, of whom 601 (50.1 percent) were male and 588 (49.9 percent) were female, were surveyed. Only 8.1 percent (n=97) of respondents were married. There was no significant difference in marital status between sexes, and the mean age at marriage was 19.7 years (SD+2.0) for male participants and 18.6 years (SD+2.4) for female participants. Married youth (mean age, 22.0+2.0 years) were generally older than their unmarried counterparts (mean age, 19.0+2.2 years, $p<0.001$).

Most participants (88.2 percent) were born in Afghanistan, with the remainder born in either Pakistan (7.3 percent) or Iran (4.3 percent). Most of those born in Afghanistan reported that their current home was in the same province in which they were born (87.3 percent, n=924). Participant distribution by home province was Balkh (33.2 percent, n=398/1200), Nangarhar (24.8 percent, n=297), Kandahar (9.3 percent, n=111), Herat (10.8 percent, n=129), Kabul (5.3 percent, n=63), Ghazni (3.1 percent, n=37), Takhar (2.3 percent, n=28), Daikundi (1.5 percent, n=18), Parwan (1.1 percent, n=13), Saripul (1.1 percent, n=13), and Ghor (1.1 percent, n=13); the remaining provinces were mentioned by fewer than 10 participants.

Service/salaried positions (30.6 percent) and agriculture/animal husbandry (24.0 percent) were the most frequently reported sources of household income, with an additional 19.2 percent reporting business/trading and 17.4 percent reporting daily labor. Nearly 15 percent (n=166) reported not

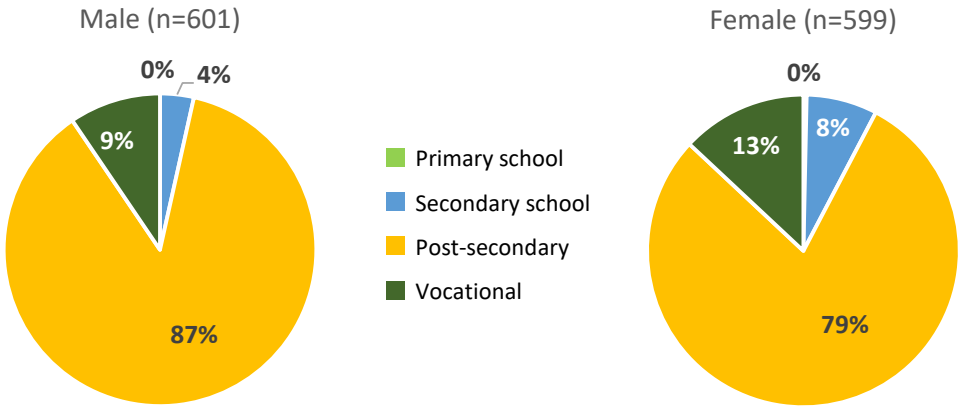
knowing their household's approximate monthly income; the mean amount among those who reported an estimate (n=1025) was 19,822 Afs (SD+30,396), and the median amount was 12,000 Afs (IQR: 8,000–20,000). Figure 3.12 shows the proportion of respondents possessing various household commodities.

Figure 3.12. Household wealth indicators among school-based youth (Afghanistan, 2017) (n=1,200)



Male and female respondents were equally represented among the 1,192 respondents who identified as a current student. Highest reported education levels are portrayed in Figure 3.13. Due to differences in educational levels and cultural norms, we segmented the remaining analysis of school-based youth by sex. We did not segment by marital status due to the low overall number of married students.

Figure 3.13. Highest education level attained by school-based youth, by sex (Afghanistan, 2017) (n=1,200)



Media exposure

Print media, such as newspapers and magazines, were not widely read by school-based youth, with similar use patterns by sex (Table 3.17). Radio and television exposure were much more common, with male students listening to radio and female students viewing television more frequently. Students from Nangarhar were among the most likely to listen at least weekly to the radio (73.0 percent versus 51.3 percent in Kandahar and 48.0 percent in Kabul, $p<0.001$).

Table 3.17. Media exposure among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Media Source	Daily	At Least Weekly	Less than Weekly	Not at All
Newspapers, magazines				
Male	5.0%	18.8%	17.8%	58.4%
Female	5.7%	16.0%	17.5%	60.8%
Radio				
Male	38.1%	17.8%	9.5%	34.6%
Female	17.2%	16.5%	12.0%	54.3%
Television				
Male	45.9%	15.3%	5.0%	33.8%
Female	59.1%	11.5%	5.3%	24.0%
Internet use*				
Male	48.3%	33.0%	18.1%	0.6%
Female	49.0%	36.9%	12.6%	1.5%

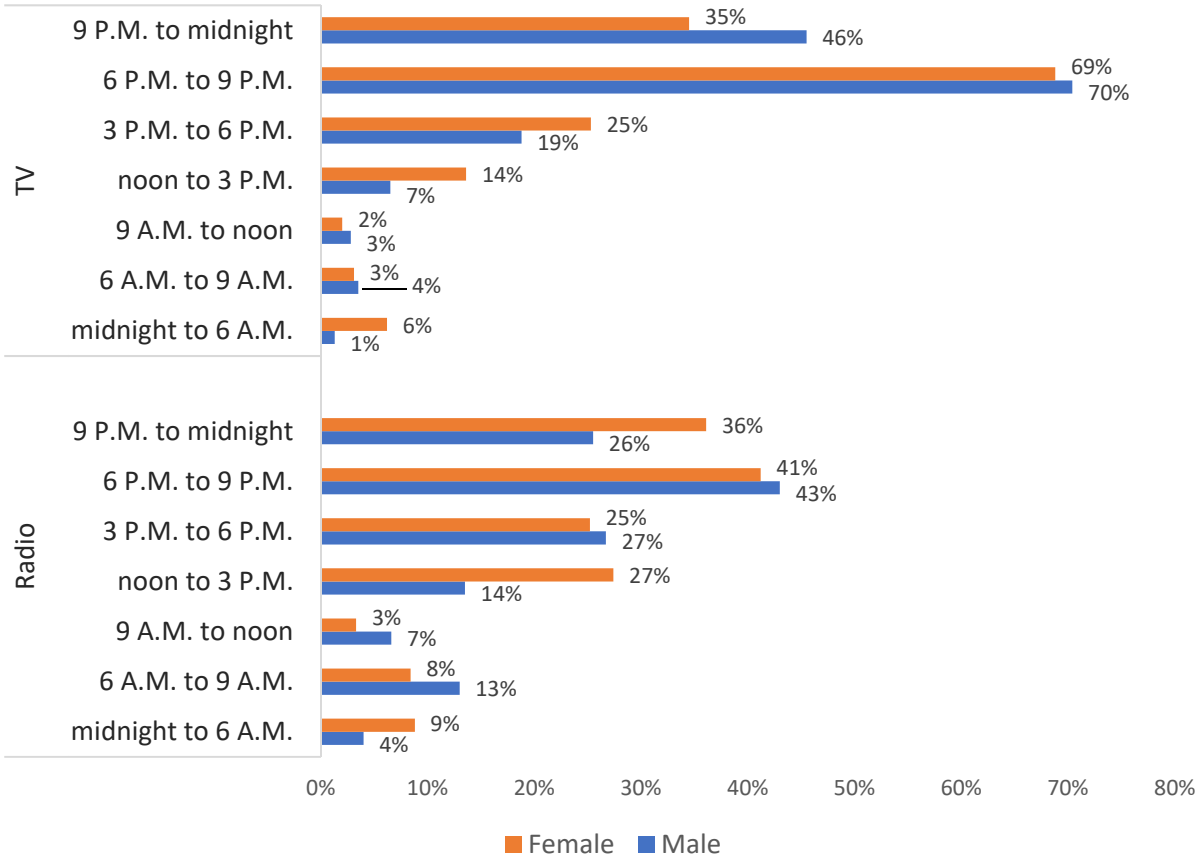
*Of 519 students (321 male, 198 female) reporting ever accessing the Internet.

Nearly half of school-based participants (56.4 percent) reported prior Internet access, with this being more common for male than female students (67.1 percent versus 45.5 percent, $p<0.001$). However, among youth accessing the Internet, exposure frequencies varied little by sex.

For those utilizing print media at least weekly (n=485), the most common topics read were news/current events (53.4 percent, n=259), sports (36.3 percent, n=176), entertainment (35.3 percent, n=171), and political/religious commentary (27.8 percent, n=135). Topic interest was similar by sex for news and political/religious commentary, but varied with female students using print media more than male students for entertainment (42.1 percent versus 30.8 percent, $p=0.01$), sports (51.1 percent versus 20.4 percent, $p<0.001$), and job advertisements (26.0 percent versus 2.8 percent, $p<0.001$). Half (52.6 percent, n=255) reported reading about health issues in the past month, with this being more common among female than male students (61.2 percent versus 34.3 percent, $p<0.001$).

The most commonly reported time intervals for listening to the radio or watching television are presented in Figure 3.14.

Figure 3.14. Most frequent radio and television viewing times among school-based youth, by sex (Afghanistan, 2017) (n=667 for radio and 853 for television)



Preferences for radio and television program content varied substantially by sex in many cases (Table 3.18).

Table 3.18. Preferences for radio and television program content among school-based youth reporting any media exposure, by sex (Afghanistan, 2017) (n=667 for radio and 853 for television)

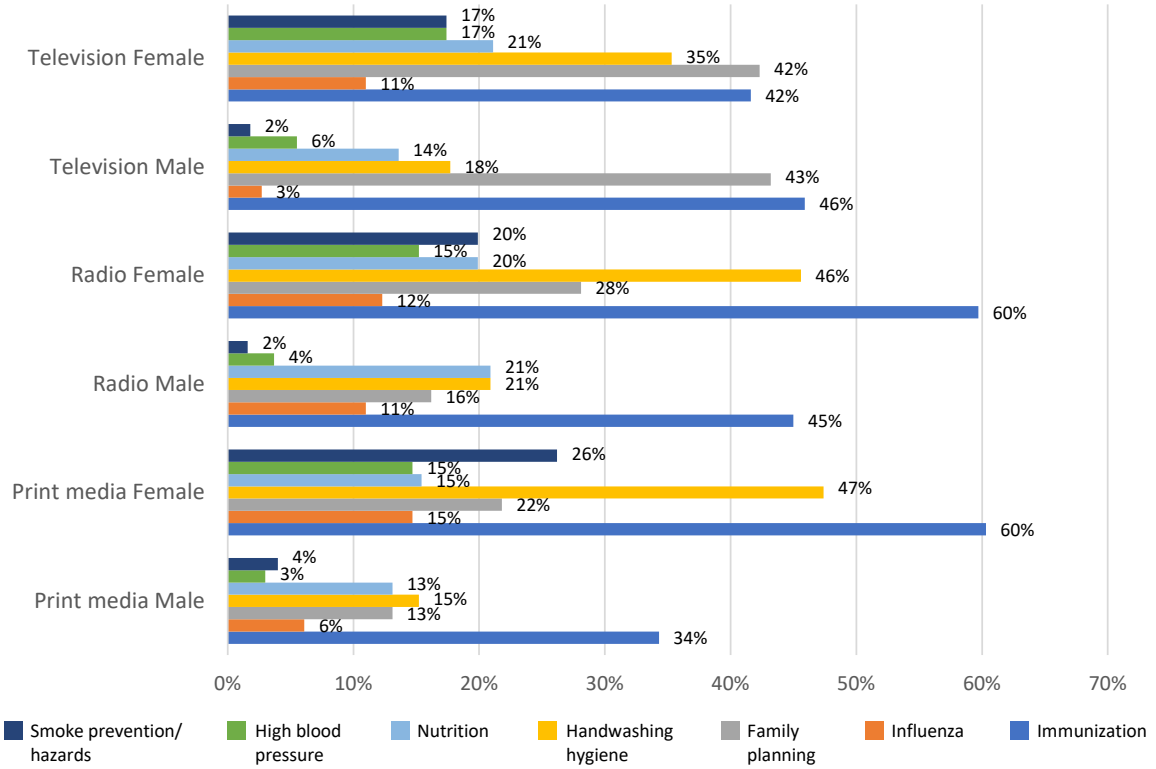
Program Content Type	Radio		Television	
	Male (n=393)	Female (n=274)	Male (n=398)	Female (n=455)
International news	42.2% (166)	33.9% (93)	36.9% (198)	30.8% (140)
National news	61.1% (240)	22.6% (62)	55.0% (219)	32.5% (148)
Local news	33.6% (132)	12.8% (35)	37.7% (398)	11.2% (51)
Music	68.3% (187)	38.7% (152)	17.1% (68)	41.8% (190)
Religion	16.3% (64)	24.1% (66)	6.3% (25)	12.3% (56)
Sports	28.2% (111)	23.7% (65)	40.5% (161)	16.3% (74)
Culture	5.9% (23)	12.4% (34)	--	--
Political debates	5.9% (23)	8.4% (23)	5.0% (20)	7.0% (32)
Entertainment	12.7% (50)	27.4% (75)	21.6% (86)	32.3% (147)
Health	13.5% (53)	15.0% (41)	---	--
Drama	4.6% (18)	17.2% (47)	43.0% (171)	77.6% (353)
Social/educational programs	2.5% (10)	13.9% (38)	10.1% (40)	17.4% (79)

Popular radio stations mentioned by school-based youth were Shamshad, En'ekas, BBC radio, Azadi, Arman, and Kileed radio, potentially reflecting different provincial/regional sampling sites. For television stations, students reported preferring Tolo, Lemar, Shamshad, Khursheed, Ariana, and 1TV stations.

Half (54.3 percent, n=362/667) of school-based youth who reported listening to the radio reported hearing health information in the past month. Female students as well as students who had sought health care in the past three months were more likely to have listened to health programming on the radio (62.4 percent versus 48.6 percent, p<0.001), as were respondents in Nangarhar (70.3 percent) and Kandahar (75.0 percent) when compared with those in Kabul (35.6 percent) or Herat (41.5 percent). A greater proportion of television-watching youth (62.8 percent, n=497/791) than of radio-listening youth reported exposure to health programming in the past month. Students from Nangarhar (82.4 percent) and Kandahar (72.8 percent) were more likely to have seen televised health programming, as were female students (68.6 percent versus 56.3 percent for male students, p<0.001).

Health topics covered by mass media sources are presented in Figure 3.15. Immunization was among the most frequently reported by male and female students across media channels. FP was reported most by television viewers, while handwashing and hygiene were reported across media channels, predominantly by female students. For all media sources, 20 to 33 percent of participants mentioned receiving information about other health topics, including dental health, skin conditions, and prevention of infectious diseases (i.e., HIV, tuberculosis, diarrhea, malaria).

Figure 3.15. Health topics received among school-based youth reporting exposure to health messages from media within the past month, by sex and media source (Afghanistan, 2017) (n=255 for print media, 362 for radio, and 537 for television)



Most (81 percent) school-based youth reported having their own mobile phones. Mobile phone ownership, based on various demographic variables, is presented in Table 3.19.

Table 3.19. Sociobehavioral variables associated with mobile phone ownership among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Sociobehavioral Variable	Male % (n)	Female % (n)	p-value
Sex	92.3 (555)	68.9 (406)	***
Province			***
Nangarhar	88.7 (133)	44.7 (63)	
Kandahar	100.0 (76)	91.8 (67)	
Kabul	100.0 (75)	97.3 (73)	
Hirat	100.0 (75)	89.3 (67)	
Balkh	87.1 (196)	60.4 (136)	
Age	Mean (SD)	Mean (SD)	***
Owns mobile phone	19.7 (2.3)	19.6 (2.1)	
Does not own mobile phone	17.0 (1.6)	17.4 (1.8)	
Household Income, Afs (n=1,021)	Mean (SD)‡	Mean (SD)	0.33
Owns mobile phone	17001 (18183)	23032 (36663)	
Does not own mobile phone	21471 (28364)	22063 (44448)	
Sought Health Care from a Medical Provider in the Past 6 Months	% (n)	%(n)	*
Yes	94.6 (281)	74.2 (239)	
No	90.1 (274)	62.5 (167)	
Marital Status	% (n)	% (n)	**
Married	100.0 (54)	86.0 (37)	
Unmarried	91.6 (501)	67.6 (369)	

*=p<0.05; **p<0.01; ***p<0.001; ‡14.6% of participants stating they did not know.

While half of school-based youth (56 percent, n=672) reported prior Internet use on smart phones, tablets, or computers, there were significant differences by sex, with male students being more likely than female students to have used the Internet (67.1 percent versus 45.5 percent, p<0.001). Among school-based youth who reported having Internet access in the past month (43.3 percent, n=519/1,200), 48.6 percent reported using the Internet almost every day and a further 34.5 percent reported using it at least once weekly. The main reasons for Internet use were e-mail/social media (59.5 percent, n=306/514), school-related work or education (21.6 percent), current events and entertainment (each 20.2 percent), sports (14.8 percent), and political or religious commentary (13.4 percent). Half (52.0 percent, 267/514) of Internet users reported accessing health information online in the past month, with a somewhat higher likelihood among female than male youth (56.9 percent versus 48.9 percent, p=0.08). The most frequent health topics searched were nutrition (17.2 percent), FP (15.7 percent), immunization (15.0 percent), handwashing and hygiene practices (13.5 percent), hypertension (12.7 percent), smoking harms/cessation (5.2 percent), and other content (58.8 percent), for which general health was frequently mentioned.

Health service-seeking behavior

Health care providers were most frequently named as the usual health information source (50 percent, n=602), more so by male than female youth (58.1 percent versus 42.2 percent, p<0.001). School-based youth listed teachers (31 percent, n=374), mothers (19 percent, n=232), and books/ newspapers (18 percent, n=22) as additional health information sources. Female youth were more likely than male youth to consult teachers (38.1 percent versus 24.3 percent, p<0.001) and mothers (30.4 percent versus 8.3 percent, p<0.001), while both sexes were equally likely to consult newspapers or books (17.6 percent for male and 19.0 percent for female, p=0.53).

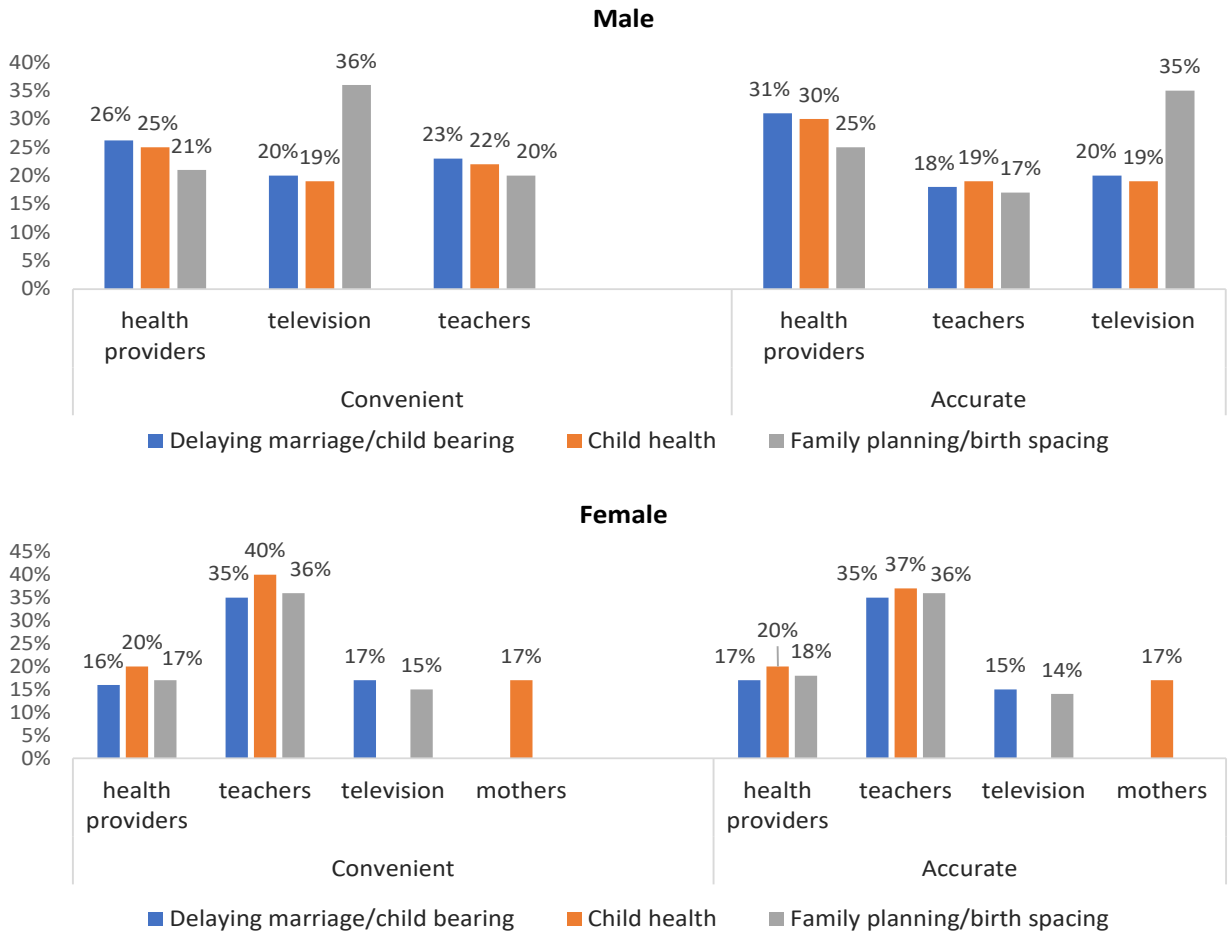
Many school-based youth (57 percent) reported receiving messages about the health benefits of delaying marriage/childbirth, and two-thirds had received information relating to child health (66 percent) and FP/birth spacing (68 percent) in the past 12 months. Receiving information on these topics was substantially more likely for female than male youth (67.6 percent versus 46.4 percent for delaying marriage, 70.8 percent versus 60.2 percent for child health, and 72.0 percent versus 63.6 percent for FP, all p<0.001). School-based youth were also asked which information sources regarding delaying marriage, child health, and FP they perceived to be most convenient and most accurate (Figure 3.16).

Table 3.20. Health counseling topics discussed with a health care provider in the last six months among school-based youth, by sex (Afghanistan, 2017) (n=595)

Topic	Male (n=279) % (n)	Female (n=316) % (n)
Health maintenance	43.0% (120)	62.7% (198)***
Tobacco smoking prevention/cessation	11.8% (33)	12.0% (38)
Accident prevention	7.9% (22)	19.0% (60)***
Stress reduction	9.3% (26)	22.5% (75)***
Depression/mental health issues	10.0% (28)	21.5% (68)***
Family planning	4.7% (13)	26.9% (85)***
Women's health	6.8% (19)	45.3% (143)***
Children's health	15.4% (43)	42.7% (135)***
Other	44.4% (124)	8.5% (27)***

*p<0.05; **p<0.01; ***p<0.001

Figure 3.16. Most convenient and most accurate health information sources reported by school-based youth, by sex (Afghanistan, 2017) (n=1,200)



Nearly all (96.3 percent) school-based youth indicated the desire for more health information. When asked in an open-ended question about the type of information they desired, the most common response was health maintenance (diet/exercise) for both male (49 percent, n=279/572) and female (55 percent, n=321/584) youth. Female participants also prioritized mental health issues and care during childbirth (both 29 percent, n=167), followed by newborn care (28 percent, n=166), and care during pregnancy (26 percent, n=154). Male participants mentioned nutrition and feeding one's family (23 percent, n=130), newborn care (15 percent, n=83), and smoking cessation (12 percent, n=69). Answers categorized as "other" were also common, more so for male (32.2 percent) than female (13.9 percent) participants, with the most frequent areas mentioned by male participants being general/complete health information (24 percent, n= 44/183) and "internal" conditions (11 percent, n=21/183). For female participants, skin conditions were mentioned by 23 percent (18/80), general health by 16 percent (13/80), and menstruation by 15 percent (12/80).

Male and female youth had similar preferences for FP/RMNCH information channels. Health care providers were most preferred (45 percent for male and 56 percent for female), with television (39 percent for male and 48 percent for female) and radio (18 percent for male and 19 percent for female) being the next most preferred. For male participants, home visits by CHWs and print media were both mentioned by 17 percent. Female participants mentioned print media (32 percent), home visits by CHWs (24 percent), and a telephone hotline (15 percent). Mobile phone messaging was spontaneously mentioned by 20 percent and 4 percent of female and male respondents, respectively.

Maternal and child health knowledge

Knowledge surrounding ANC, pregnancy risks/complications, and delivery risks/complications is presented in Table 3.21. Though most participants were not yet married, this information was still relevant since many of these youth are exposed to the information and serve as an information resource within their families due to their advanced education. While most (92.8 percent) school-based youth correctly agreed with statements related to the importance of ANC visits, respondents were generally less knowledgeable of the types of pregnancy and delivery risks faced by women. Further, while youth generally agreed that women who become pregnant before 18 years of age face greater risk of pregnancy complications (92.6 percent overall), they were less likely to know specific types of pregnancy and delivery complications this population could encounter.

Table 3.21. Knowledge of antenatal care, pregnancy complications, and labor/delivery risks among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Maternal Health Statement	Male (n=601)		Female (n=599)	
	%	n	%	n
Pregnant women should have ANC visits even if they feel well	88.7	533	97.0	581
Pregnant women should have at least four ANC visits	93.0	559	96.7	579
Serious conditions that could be life-threatening during pregnancy				
At least one condition identified (among those reporting at least one condition)	68.7	413	85.0	509
Bleeding	41.9	173	79.0	402
Severe headache	20.3	84	39.3	200
Severe weakness	24.7	102	25.1	128
Loss of consciousness	12.1	50	28.5	145
Severe abdominal pain	16.7	69	20.0	102
Swollen hands/face	7.0	29	33.2	169
Fever	6.3	26	18.9	96

Maternal Health Statement	Male (n=601)		Female (n=599)	
	%	n	%	n
Blurred vision	3.6	15	18.3	93
Convulsions	8.5	35	23.4	119
Difficulty breathing	9.2	38	20.0	102
Premature rupture of membranes	2.2	9	17.9	91
Reduced fetal movement	3.8	23	14.5	74
Other condition	42.4	175	22.8	116
No response	0	0	1.5	9
Do not know	31.3	188	16.7	100
No conditions	0.2	1	0	0
What women can do to reduce health risks during pregnancy				
At least one action identified (among those reporting at least one action)	88.0	529	91.5	548
Regular ANC visits to midwife/doctor	64.5	341	90.5	496
Avoid inappropriate foods	32.1	170	54.6	299
Take traditional medicine	4.2	22	21.4	117
Consult with mother-in-law or mother	4.9	26	11.9	65
Consult a *dayee*	6.0	32	13.0	71
Consult a religious leader	1.7	9	2.2	12
Do not do heavy work	22.9	121	3.3	18
Other actions	36.9	195	16.8	92
Do not know	0	0	0.3	2
Nothing	12.0	72	8.7	52
Conditions women younger than 18 years might face during delivery				
At least one condition identified (among those reporting at least one condition)	61.2	368	75.0	449
Pre-eclampsia	37.2	137	59.9	269
Severe headache	21.5	79	38.5	173
Blurred vision	7.3	27	18.5	83
Convulsions	11.1	41	31.2	140
Swollen hands/face	7.3	27	26.7	120
Baby cannot pass through birth canal	57.9	213	59.9	269
Preterm labor/delivery	29.3	108	41.2	185
No answer	4.4	20	0.7	8
Do not know	31.9	144	31.3	375
Potential obstetric complications during labor and delivery				
At least one complication identified	67.7	407	80.5	482
(among those reporting at least one condition)	(n=407)		(n=482)	
Severe bleeding	69.0	281	90.2	435
Loss of consciousness	18.9	77	36.3	175
High fever	12.3	50	36.9	178
Convulsions	14.3	58	37.6	181
Prolonged labor (>12 hours)	17.0	69	42.7	206
Baby in wrong position/malpresentation	21.9	89	30.3	146
Placenta not delivered within 30 minutes of birth	3.9	16	19.5	94

Maternal Health Statement	Male (n=601)		Female (n=599)	
	%	n	%	n
Other condition	19.7	80	16.2	78
No answer	0.3	2	0.8	5
Do not know	31.9	194	18.7	112

Not knowing a potential labor and delivery complication was more likely for male than female participants (32.3 percent versus 18.9 percent, p<0.001), for younger than older participants (mean age, 18.0 years versus 19.7 years), and for youth residing in Nangarhar and Kabul (29.0 percent and 21.3 percent, respectively) than those living in Herat (8.7 percent) and Kandahar (0.0 percent).

Three-quarters of school-based youth affirmed that women could die from pregnancy complications. Female students were more likely than male peers to agree (79.6 percent versus 71.0 percent, p=0.001), and 27.1 percent of male students versus 19 percent of female students stated they didn't know. Nearly all (98 percent) school-based youth identified health facilities as the best place for a woman to deliver, with little variance by sex (96.7 percent for male versus 99.5 percent for female students). However, reasons for preferring facility-based deliveries did differ by sex. Male students mentioned better care (92.5 percent) more frequently than safety (73.5 percent), while female students mentioned better care and safety with equal frequency (64.1 percent for both). One-third of female participants reported facility-based delivery as less expensive, while only 2.2 percent of male youth listed this reason. Ease of access was mentioned by 42 percent of female youth and 31 percent of male youth.

Newborn care knowledge

While most school-based youth were unmarried, they reported exposure to child health messages as well as desire for greater knowledge about infant care and child health. For that reason, we analyzed infant and child knowledge among this group to describe important gaps and potentially direct future messaging. Responses to these questions are presented in Table 3.22.

Table 3.22. Knowledge of newborn care, including appropriate cord care, newborn temperature regulation, and initiation of breastfeeding among school-based youth, by sex (Afghanistan, 2017) (n=1200)

Newborn Health Statement	Male (n=601)		Female (n=599)	
	%	n	%	n
Appropriate cord care				
At least one action identified	64.7	389	80.5	482
Keep cord dry	29.6	115	61.4	296
Chlorhexidine daily for one week	38.6	150	26.6	128
Apply something else to the cord stump	19.5	76	8.1	39
Other action	12.3	48	3.9	19
Do not know	35.1	211	19.5	117
Best way to regulate newborn's body temperature				
At least one action identified	86.9	522	85.6	513
Wrap/swaddle the baby	59.0	308	53.0	272
Put hat on baby's head	60.0	266	17.5	90
Make sure room is warm	47.9	250	56.5	290

Newborn Health Statement	Male (n=601)		Female (n=599)	
	%	n	%	n
Keep baby wrapped on mother's chest	11.9	62	39.8	204
Delay bathing the baby	5.7	30	20.9	107
Do not know	13.1	79	15.3	86
When to initiate breastfeeding				
Within one hour of birth	52.1	313	76.5	458
Within several hours of birth	20.3	122	5.2	31
Within one day	6.5	39	2.2	13
Within several days	2.0	12	1.0	6
When the white milk comes in	4.8	29	7.5	45
Do not know	14.3	86	7.7	46

CHX knowledge (measured through the spontaneous statement that CHX application to the umbilical stump daily for five days is best for cord care) did not vary significantly by sex (25.0 percent [n=150] for male versus 21.4 percent, [n=128] for female, p=0.14). We analyzed associations between CHX knowledge and several key variables, segmented by sex, and conducted adjusted multivariable logistic regression analysis to determine independent associations, with the most parsimonious model presented (Table 3.23). School-based youth from Kandahar had higher levels of CHX knowledge, particularly among female participants. For both sexes, age was associated with CHX knowledge, with this association remaining significant in adjusted analysis for male participants. In bivariate analysis, several associations differed markedly by sex, such as for marital status, regular television viewing, and health care utilization in the past six months.

Table 3.23. Correlates of knowledge of chlorhexidine use for umbilical cord care among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Variable	Male (n=601)	AOR (95% CI)	Female (n=599)	AOR (95% CI)†
Overall %	25.0	---	21.4	---
Age, mean±SD	20.1± 2.4 vs. 19.3± 2.3***	1.10 (1.00–1.20)	19.7± 2.5 vs. 18.7± 2.1***	
Province	***		***	
Balkh	21.8	0.93 (0.55–1.57)	9.3	0.47 (0.25–0.87)
Herat	32.0	1.21 (0.61–2.41)	4.0	0.19 (0.36–0.65)
Kabul	4.0	0.11 (0.03–0.37)	14.7	0.78 (0.36–1.68)
Kandahar	51.3	2.28 (1.17–4.45)	89.2	37.6 (16.2–87.4)
Nangarhar	23.3	Reference	18.0	Reference
Married	40.7 vs. 23.4**		25.6 vs. 21.0	
Has own mobile phone	25.9 vs. 13.0*		22.7 vs. 15.3*	
Prior Internet use	26.4 vs. 21.8		20.4 vs. 21.4	
View television at least weekly	19.3 vs. 33.9***	0.56 (0.37–0.85)	22.2 vs. 19.3	
Listen to radio at least weekly	25.3 vs. 24.5		18.3 vs. 22.9	
Saw health provider in past 6 months	23.2 vs. 26.6		28.1 vs. 13.1***	

*p≤0.05; **p≤0.01; ***p≤0.001; †adjusted for age.
CI=confidence interval; n=number; OR=odds ratio

Regarding breastfeeding initiation, female youth were more likely than male youth to know the correct answer of within one hour of birth (Table 3.2; p<0.001). There was greater diversity in correct breastfeeding initiation knowledge among female than male students by province, age, and health care access (Table 3.24). Mobile phone ownership, watching television at least weekly, and marital status were not associated with correct timing of breastfeeding initiation knowledge in multivariable analysis for either sex.

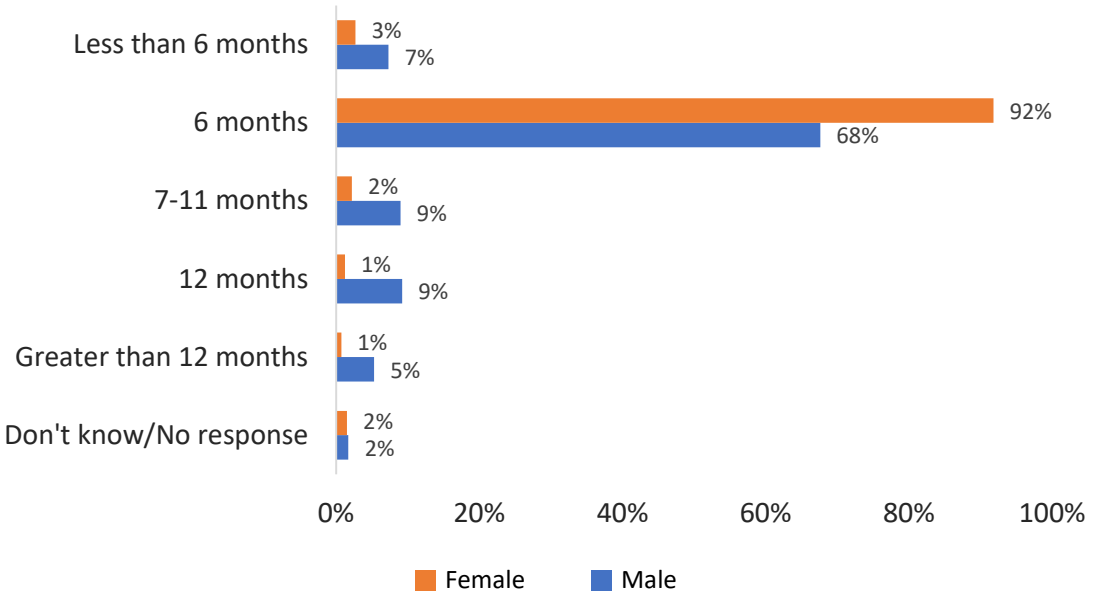
Table 3.24. Factors independently associated with knowledge of correct timing of breastfeeding initiation among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Sociodemographic Variable	OR (95% CI)	
	Female Youth	Male Youth
Health care sought from provider in past 6 months		
No	Reference	Reference
Yes	1.85 (1.13–3.03)*	1.15 (0.82–1.60)
Region		
Nangarhar	Reference	Reference
Kandahar	0.06 (0.02–0.15)***	1.12 (0.60–2.09)
Kabul	0.14 (0.05–0.38)***	0.63 (0.35–1.15)
Herat	1.50 (0.29–7.74)	0.69 (0.37–1.27)
Balkh	0.09 (0.04–0.21)***	1.29 (0.85–1.97)
Age		
Continuous	1.20 (0.07–4.42)	1.08 (0.99–1.17)

*p<0.05; **p<0.01; *** p<0.001.

Nearly all (96.5 percent of male and 97.8 percent of female youth) stated that breast milk alone was the best thing to feed an infant under six months of age. When respondents were asked to specify the number of months an infant should be exclusively breastfed, most knew the correct duration of six months, with more female respondents providing the correct response (Figure 3.17).

Figure 3.17. Knowledge of exclusive breastfeeding duration (in months) among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

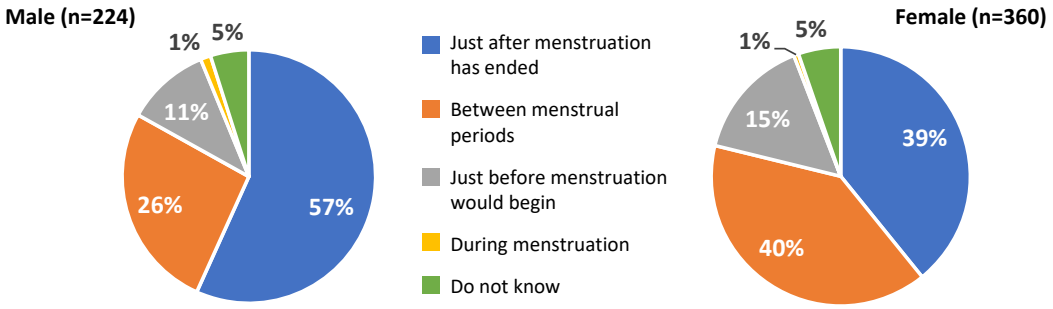


Fewer youth knew how long young children should continue breastfeeding with complementary feeding with solids; 55.7 percent of male and 50.6 percent of female students correctly stated 24 months, while 22.0 percent of male and 30.9 percent of female students stated less than 24 months, clustering at 12 months among male (7.2 percent, n=43) and female (5.8 percent, n=35) youth. There was also notable clustering at 30 months for both male (12.3 percent, n=74/601) and female (10.7 percent, n=64/599) respondents.

Family planning knowledge

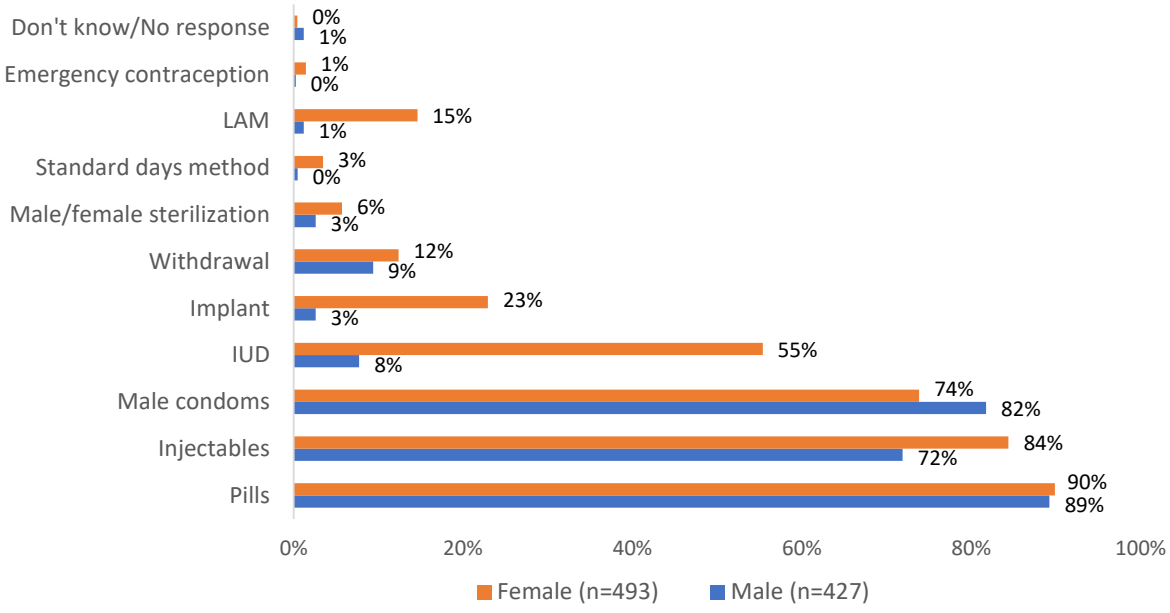
About half (48.7 percent, n=584/1,200) of school-based youth reported having heard that fertility increases during certain portions of the menstrual cycle, with female youth more likely than male youth to be aware (60.1 percent versus 37.3 percent, p<0.001). Correct knowledge of peak fertility timing varied by sex (Figure 3.18).

Figure 3.18. Knowledge of peak fertility among school-based youth, by sex (Afghanistan, 2017) (n=584)



While more than three-quarters of students (76.7 percent, n=920) reported having heard of birth spacing or ways for couples to delay/avoid pregnancy, FP awareness was significantly higher among female than among male respondents (82.3 percent versus 71.1 percent, p<0.001). School-based youth were generally aware of FP and willing to discuss it, so we proceeded with a sex-specific analysis without consideration of marital status. Awareness of specific FP methods by sex is presented in Figure 3.18.

Figure 3.19. Awareness of family planning methods among school-based youth, by sex (Afghanistan, 2017) (n=1,200)



Few school-based youth could correctly identify the length of time that exclusive breastfeeding is effective for preventing pregnancy, as only 19.0 percent (n=228) correctly responded six months. More than 40 percent of respondents stated not knowing the duration of pregnancy prevention with LAM, though more female than male students (23.4 percent versus 14.6 percent, p<0.001) knew that LAM duration is a maximum of six months. Additional factors associated with knowledge of correct LAM duration varied by sex in bivariate logistic regression analysis (Table 3.25).

In multivariable analysis, receiving health care in the past six months (AOR=6.84, 95 percent CI: 3.98–11.75), owning a mobile phone (AOR=3.32, 95 percent CI: 1.76–6.25), recruitment in Balkh (AOR=8.03, 95 percent CI: 4.05–15.9) or Herat (AOR=3.41, 95 percent CI: 1.54–7.55), and age remained independently correlated with knowledge of correct LAM duration among female respondents. For male respondents, only recruitment in Kandahar (AOR=10.0, 95 percent CI: 4.98–20.10) was independently associated with knowledge of correct LAM duration.

Table 3.25. Factors associated with knowledge of correct LAM duration in bivariate analysis among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Sociodemographic Variable	OR (95% CI)	
	Female	Male
Prior Internet use		
No	Reference	Reference
Yes	1.50 (1.02–2.19)*	1.13 (0.69–1.84)
Mobile phone ownership		
No	Reference	Reference
Yes	4.19 (2.44–7.21)***	2.59 (0.79–8.55)
Married		
No	Reference	Reference
Yes	1.65 (0.84–3.21)	2.78 (1.47–5.24)**
Health care sought from provider in past 6 months		
No	Reference	Reference
Yes	3.57 (2.31–5.52)***	1.34 (0.85–2.12)
Watch television		
< Weekly	Reference	Reference
Once or more weekly	1.40 (0.90–2.16)	0.65 (0.41–1.02)
Province		
Nangarhar	Reference	Reference
Kandahar	1.51 (0.68–3.36)	10.0 (4.98–20.1)***
Kabul	1.49 (0.67–3.31)	0.93 (0.36–2.38)
Herat	3.68 (1.83–7.42)***	0.38 (0.11–1.34)
Balkh	3.91 (2.20–6.96)***	1.02 (0.52–2.03)
Age (continuous)	1.24 (1.14–1.35)***	1.20 (1.09–1.32)***

*p<0.05; **p<0.01; ***p<0.001.
CI=confidence interval; n=number; OR=odds ratio

The four statements measuring FP knowledge in Table 3.26 are notable for substantial differences by sex and high rates of "do not know" responses among all respondents. These questions were asked of all participants, regardless of familiarity with specific FP methods.

Table 3.26. Agreement with family planning statements among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Family Planning Knowledge Statement	Agree % (n)	Disagree % (n)	Do Not Know % (n)	No Response % (n)
Withdrawal is a highly effective method for preventing pregnancy.				
Male youth	46.1 (277)	32.8 (197)	19.1 (115)	2.0 (12)
Female youth	56.4 (338)	10.9 (65)	32.1 (192)	0.7 (4)

Family Planning Knowledge Statement	Agree % (n)	Disagree % (n)	Do Not Know % (n)	No Response % (n)
Young women should not use family planning methods because it may create problems getting pregnant later.				
Male youth	56.6 (340)	28.8 (173)	13.3 (80)	1.3 (8)
Female youth	48.8 (292)	32.2 (193)	17.9 (107)	1.2 (7)
The IUCD or loop can prevent pregnancy for up to 10 years.				
Male youth	16.3 (98)	28.6 (172)	53.2 (320)	1.8 (11)
Female youth	47.6 (285)	21.5 (129)	30.4 (182)	0.5 (3)
Irregular periods or bleeding between periods while using the injection or implant will usually resolve on its own.				
Male youth	22.5 (135)	29.6 (178)	47.1 (283)	0.8 (5)
Female youth	50.8 (304)	16.4 (98)	31.9 (191)	1.0 (6)

We further explored correlates of correct responses to the FP statements in bivariate logistic regression analysis (Table 3.27). There were marked differences by sex, with correct knowledge regarding popular FP misconceptions reflected by agreement or disagreement with the four FP statements.

For both male and female respondents, mobile phone ownership was positively correlated and watching television once or more weekly was negatively correlated with disagreement that withdrawal is an effective FP method. Province of recruitment, age, and prior Internet use were also positively correlated for female respondents only. Male respondents from Herat were less likely than those from other provincess to disagree with the statement. In sex-specific multivariable analysis, for male participants, owning a mobile phone (AOR=2.77, 95 percent CI: 1.25–6.13) remained positively correlated, while watching television at least weekly (AOR=0.69, 95 percent CI: 0.48–1.00) and recruitment in Herat (AOR=0.40, 95 percent CI: 0.20–0.77) remained negatively correlated with disagreement that withdrawal is an effective FP method. Among female participants, only 525 remained in the multivariable model; as no Kandahar-recruited participants provided a correct response, they were excluded in the model. In the adjusted model, age (AOR=1.21, 95 percent CI: 1.04–1.40) and recruitment in Kabul (AOR=4.28, 95 percent CI: 1.42–12.9), Balkh (AOR=3.19, 95 percent CI: 1.11–9.14), and Herat (AOR=20.9, 95 percent CI: 7.14–61.5) were independently positively correlated, while watching television once or more weekly (AOR=0.33, 95 percent CI: 0.17–0.63) remained negatively correlated.

For female participants, disagreement with the statement that hormonal FP methods cause permanent sterility among young women was positively correlated with age, recruitment from any site except Nangarhar, mobile phone ownership, prior Internet use, and obtaining health care from a provider within the past six months. For male participants, no factors were correlated with disagreeing with this misconception. In multivariable analysis, only recruitment outside Nangarhar (Kandahar: AOR=39.2, 95 percent CI: 17.5–87.7; Herat: AOR=9.63, 95 percent CI: 4.47–20.8; Kabul: AOR=7.62, 95 percent CI: 3.51–16.5; Balkh: AOR=6.92, 95 percent CI: 3.48–13.7) and having received care from a health provider in the past six months (AOR=2.01, 95 percent CI:1.34–3.03) remained correlated with disagreement with this misconception.

Agreement with the statement regarding correct duration of IUCD efficacy was associated with being married and having seen a medical provider in the past six months, for both sexes. For female respondents, age was also positively correlated, while recruitment from all provinces except Nangarhar and prior Internet use were negatively correlated. In multivariable analysis, age (AOR=1.20, 95 percent CI: 1.10–1.32) and receiving care from a provider in the past six months (AOR=1.87, 95 percent CI: 1.26–2.78) were independently correlated with knowledge of correct duration of IUCD efficacy among female participants;

province of recruitment remained negatively correlated (Kandahar: AOR=0.08, 95 percent CI: 0.04–0.16; Kabul: AOR=0.13, 95 percent CI: 0.06–0.25; Herat: AOR=0.29, 95 percent CI: 0.15–0.55; Balkh: AOR=0.19, 95 percent CI: 0.11–0.31). For male participants, recruitment in Herat (AOR=6.14, 95 percent CI: 2.60–14.5) remained positively correlated, while age (AOR=1.22, 95 percent CI: 1.09–1.36) emerged as positively correlated in the most parsimonious model.

Among female participants, having seen a health care provider in the past six months, age, Internet use, and mobile phone ownership were all positively correlated with agreeing that irregular bleeding symptoms with hormonal contraception lessen over time, though female respondents from Kabul and Balkh were less likely to agree. Among male participants, age and having seen a health care provider in the past six months were also positively correlated, as was recruitment from Kandahar; watching television at least weekly was negatively correlated. In multivariable analysis for female participants, receiving care from a provider in the past six months (AOR=2.71, 95 percent CI: 1.77–4.14), age (AOR=1.16, 95 percent CI: 1.04–1.29), and mobile phone ownership remained independently positively correlated, while recruitment from Kabul (AOR=0.08, 95 percent CI: 0.04–0.18) or Balkh (AOR=0.17, 95 percent CI: 0.10–0.30) remained negatively correlated. For male participants, age (AOR=1.20, 95 percent CI: 1.08–1.32) and recruitment from Kandahar (AOR=2.73, 95 percent CI: 1.39–5.36) remained independently correlated, while recruitment from Kabul (AOR=0.28, 95 percent CI: 0.12–0.66) or Balkh (AOR=0.58, 95 percent CI: 0.33–1.00) were independently negatively correlated.

Table 3.27. Factors associated with selected correct family planning knowledge statements among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Sociodemographic Variable†	OR (95% CI)			
	Female	Male	Female	Male
Disagree with statement	***"Withdrawal (el azl) is a highly effective method for preventing pregnancy."***		***"Young women should not use family planning methods because it may create problems getting pregnant later."***	
Prior Internet use	(n=593) 1.80 (1.06–3.03)*	(n=599) 0.90 (0.62–1.29)	(n=593) 2.19 (1.54–3.11)***	(n=599) 1.02 (0.70–1.49)
Mobile phone ownership	(n=589) 3.50 (1.63–7.50)**	2.45 (1.12–5.36)*	(n=589) 2.44 (1.61–3.68)***	1.02 (0.53–2.00)
Married	1.09 (0.41–2.87)	1.03 (0.57–1.86)	1.27 (0.67–2.42)	1.05 (0.57–1.93)
Health care sought from provider in past 6 months	1.08 (0.64–1.81)	1.15 (0.82–1.62)	1.73 (1.21–2.46)**	0.71 (0.50–1.01)
Watch television				
Less than weekly	Reference	Reference	Reference	Reference
Once or more weekly	0.41 (0.24–0.69)**	0.67 (0.48–0.95)*	1.07 (0.73–1.55)	0.87 (0.61–1.25)
Province	(n=525, Kandahar dropped)			
Nangarhar	Reference	Reference	Reference	Reference

Sociodemographic Variable†	OR (95% CI)			
	Female	Male	Female	Male
Kandahar	All incorrect	1.26 (0.71–2.21)	38.6 (17.3–85.9)***	0.81 (0.44–1.49)
Kabul	6.08 (2.08–17.8)**	0.63 (0.34–1.16)	6.10 (2.86–13.02)***	1.27 (0.71–2.26)
Herat	19.3 (7.08–52.8)***	0.43 (0.22–0.83)*	7.67 (3.62–16.22)***	0.67 (0.36–1.26)
Balkh	2.37 (0.86–6.57)	0.86 (0.56–1.33)	4.98 (2.59–9.59)***	0.74 (0.47–1.16)
Age (continuous)	1.26 (1.12–1.41)***	1.05 (0.98–1.13)	1.26 (1.16–1.36)***	0.98 (0.91–1.06)
Agree with statement	***"The IUCD or loop can prevent pregnancy for up to 10 years."***		***"Irregular periods or bleeding between periods while using the injection or implant will usually resolve on its own."***	
Prior Internet use	(n=593) 0.71 (0.51–0.99)*	(n=599) 2.29 (1.34–3.91)**	(n=593) 2.19 (1.54–3.11)***	(n=599) 1.02 (0.70–1.49)
Mobile phone ownership	(n=589) 1.06 (0.75–1.51)	4.60 (1.10–19.3)*	(n=589) 2.44 (1.61–3.68)***	1.02 (0.53–2.00)
Married	2.17 (1.13–4.16)*	2.64 (1.42–4.92)**	1.27 (0.67–2.42)	1.05 (0.57–1.93)
Health care sought from provider in past 6 months	2.75 (1.97–3.85)***	1.77 (1.14–2.76)*	4.34 (3.08–6.13)***	1.67 (1.13–2.46)*
Watch television				
Less than weekly	Reference	Reference	Reference	Reference
Once or more weekly	0.74 (0.52–1.06)	0.74 (0.48–1.14)	0.92 (0.65–1.30)	0.63 (0.43–0.93)*
Province				
Nangarhar	Reference	Reference	Reference	Reference
Kandahar	0.14 (0.08–0.26)***	1.26 (0.71–2.21)	1.05 (0.56–1.96)	4.80 (2.64–8.74)***
Kabul	0.16 (0.08–0.29)***	0.63 (0.34–1.16)	0.12 (0.06–0.23)***	0.44 (0.19–1.01)
Herat	0.35 (0.20–0.64)**	0.43 (0.22–0.83)	1.85 (0.92–3.72)	1.00 (0.51–1.97)
Balkh	0.16 (0.10–0.25)***	0.86 (0.56–1.33)	0.15 (0.09–0.23)***	0.70 (0.41–1.19)
Age (continuous)	1.26 (1.12–1.41)***	1.05 (0.98–1.13)	1.26 (1.16–1.36)***	1.22 (1.12–1.32)***

*p≤0.05; **p≤0.01; ***p≤0.001; †denotes numbers less than 601 for male youth and 599 for female youth.

Care utilization and sources of health information

Half (50.0 percent) of students reported seeking care at a health facility in the past three months, with female youth significantly more likely to seek care than male youth (54.5 percent versus 45.5 percent, p=0.001). Table 3.28 presents factors associated with seeking care at a facility in the past three months for key sociodemographic characteristics and media access.

Sources consulted first for general health questions were similar by sex, with both male and female participants favoring health providers (73.4 percent and 58.4 percent, respectively) and CHWs (16.0 percent and 23.9 percent, respectively). Female participants were more likely than male participants to report their mothers as a preferred health information source (41.6 percent versus 14.6 percent), but male participants were more likely to report their fathers (15.0 percent versus 7.9 percent).

The preferred sources for FP/RMNCH issues generally mirrored those mentioned for general health. For male and female students, doctors and midwives were the most preferred (71.1 percent and 60.9 percent, respectively), followed by CHWs (14.5 percent and 19.2 percent), mothers (10.5 percent and 40.9 percent), teachers (7.8 percent and 23.2 percent), and books/print materials (8.5 percent and 15.5 percent).

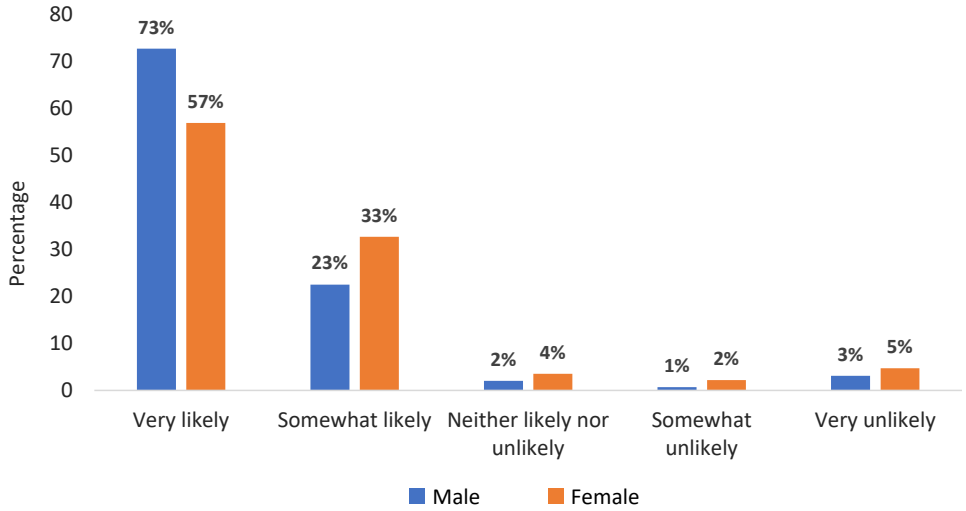
Table 3.28. Associations between key variables and health care-seeking behavior in the past three months among school-based youth, by sex (Afghanistan, 2017) (n=1200)

Sociodemographic Variable	OR (95% CI)	
	Female	Male
Province		
Nangarhar	Reference	Reference
Kandahar	0.46 (0.22–0.96) *	9.36 (4.35–20.2)***
Kabul	0.05 (0.03–0.11)***	0.46 (0.25–0.84) *
Herat	0.17 (0.08–0.32)***	0.79 (0.45–1.40)
Balkh	0.07 (0.04–0.12)***	0.85 (0.56–1.30)
Age	1.06 (0.98–1.14)	1.21 (1.12–1.29)***
Married	1.61 (0.84–3.08)	2.85 (1.57–5.20)**
Watch television at least weekly	0.60 (0.42–0.87)**	0.68 (0.49–0.95)*
Own mobile phone	1.01 (0.71–1.44)	2.52 (1.28–4.98)**
Income (quartile)		
Lowest	Reference	Reference
Second	1.15 (0.55–2.39)	0.39 (0.19–0.77)**
Middle	0.75 (0.38–1.47)	0.59 (0.31–1.13)
Highest	0.42 (0.23–0.77)**	0.67 (0.38–1.18)

*p<0.05; ** p<0.01; *** p<0.001.
CI=confidence interval; n=number; OR=odds ratio

A majority of school-based youth responded in the affirmative when asked if they would be likely to use a free mobile phone-based service for RH information, which was greater for male than female participants (95.0 percent versus 89.7 percent, p<0.001; Figure 3.19). Among male participants, no factors were associated with likelihood of mobile phone program use, but female participants enrolled in Kabul (84.0 percent) and Balkh (84.9 percent) were less likely to desire service use (p=0.002).

Figure 3.20. Likelihood of school-based youth using a free mobile phone-based service for health advice, by sex (Afghanistan, 2017) (n=1200)



Among school-based youth, 75.7 percent of male and 74.6 percent of female youth would prefer to speak to a live person, while 22.5 percent of male and 23.0 percent of female youth stated a preference for a recorded message. We did not inquire about preference for written text messages.

Family decision making, marital status, and marriage attitudes

Less than 10 percent of school-based youth were married, with no difference by sex (9.0 percent for male and 7.2 percent for female). The mean age at marriage was somewhat older for male than female youth (19.7+2.0 years versus 18.6+2.4 years, p=0.01). Equal proportions of male participants met their spouse on their wedding day as those who knew their spouse for at least one year before marriage (23/54 for both scenarios). More than half of married female participants (28/51) had known their spouse for at least one year. A further 9.5 percent of unmarried male and 11.9 percent of unmarried female respondents were engaged; the mean age of engagement was 20.3+1.7 years among male youth and 17.3+3.1 years among female youth.

Female participants were more likely than male participants to respond that their family (40.4 percent versus 50.0 percent) or their spouse's family (25.7 percent versus 2.8 percent) chose their spouse or fiancée; 37.7 percent of married or engaged male youth reported choosing their own spouse, compared with 23.9 percent of their female counterparts. Female students were more likely than their male peers to report being asked if they wanted to proceed with the arrangement (91.1 percent versus 71.1 percent). Few male (9.4 percent) and female (10.1 percent) school-based youth reported that the choice was made by mutual consent with their fiancé or spouse.

We further queried perceived social norms around marriage (Table 3.29). Generally, female participants were more likely to agree with statements valuing delay of marriage beyond adolescence, while male participants were more likely to agree with statements regarding young adults choosing their own spouses.

Table 3.29. Perceived social norms and attitudes regarding marriage timing and spousal selection, among school-based youth, by sex (Afghanistan, 2017) (n=1,200)

Statement	Male			Female		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree
It is better marrying at age 16 than at age 24 years.	19.8% (119)***	2.0% (12)	78.2% (470)	3.7% (22)	1.7% (10)	94.7% (567)
Marriage should be before first menstruation.	16.6% (100)***	12.2% (73)	71.2% (428)	1.0% (6)	1.3% (8)	97.7% (585)
The ideal age at marriage is less than 24 years old.	66.4% (399)**	7.7% (46)	26.0% (156)	74.0% (443)	7.9% (47)	18.2% (109)
The ideal age at marriage is more than 24 years old.	55.4% (333)	11.3% (68)	33.3% (200)	52.6% (315)	17.2% (103)	30.2% (181)
Women should control when they marry.	72.9% (438)**	9.8% (59)	17.3% (104)	65.3% (391)	11.5% (69)	23.2% (139)
Men should control when they marry.	91.7% (551)**	4.3% (26)	4.0% (24)	86.1% (516)	7.5% (45)	6.3% (38)
It is better for young people to choose whom they marry.	90.4% (543)	6.0% (36)	3.7% (22)	89.7% (537)	5.3% (32)	5.0% (30)
It is better for parents to choose whom their children marry.	46.9% (282)***	13.0% (78)	40.1% (241)	63.4% (380)	11.4% (68)	25.2% (151)
Parental consent (for marrying) is required.	91.4% (549)***	4.7% (28)	4.0% (24)	98.8% (592)	0.7% (6)	0.5% (3)

Statement	Male			Female		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree
Parents should have a young person's consent as a requirement before marrying.	91.2% (548)***	5.8% (35)	3.0% (18)	97.7% (585)	1.7% (10)	0.7% (4)
Love marriage is good.	74.5% (448)***	8.0% (48)	17.5% (105)	53.8% (322)	15.0% (90)	31.2% (187)
It is better to know your future husband/wife before you marry.	91.4% (549)**	4.8% (29)	3.8% (23)	95.2% (570)	3.3% (20)	1.5% (9)
It is acceptable to meet him/her on the day of the wedding.	32.6% (196)**	6.2% (37)	61.2% (368)	25.4% (152)	3.8% (23)	70.8% (424)

*p<0.05; **p<0.01; ***p<0.001.

Attitudes regarding gender equity and norms within marital relationships, including those for intimate partner violence (IPV), were analyzed for both male and female school-based youth, revealing substantial differences by sex (Table 3.30). Statements surrounding IPV elicited the strongest reactions, with few participants responding "do not know" or declining to respond. In several scenarios, female participants were more likely to endorse statements in which wife beating was perceived to be justified.

Table 3.30. Attitudes regarding perceived gender equity and norms within marriage among school-based youth, by sex (Afghanistan, 2017) (n=1,200)†

Attitude Statement	Student			
	Male % Agree	Female % Agree	Male % Disagree	Female % Disagree
A husband is justified to beat his wife if she goes out without telling him.	33.0 (n=198)	28.4 (n=170)	65.7 (n=395)	80.0 (n=425)
A husband is justified to beat his wife if she neglects the children.	17.1 (n=103)***	29.4 (n=176)	81.7 (n=491)	70.1 (n=420)
A husband is justified to beat his wife if she argues with him.	21.0 (n=126)*	26.9 (n=161)	77.7 (n=467)	71.5 (n=428)
A husband is justified to beat his wife if she burns the food.	7.5 (n=45)**	13.0 (n=78)	91.9 (n=552)	85.8 (n=514)
A husband is justified to beat his wife if she refuses to have sex with him.	18.0 (n=108)	21.7 (n=130)	75.7 (n=455)	62.4 (n=374)
Contraception is a woman's business and a man should not have to worry about it.	25.5 (n=153)***	34.1 (n=204)	66.4 (n=399)	50.4 (n=302)
Women who use contraception may become promiscuous.	44.1 (n=265)	40.1 (n=240)	36.1 (n=217)	27.1 (n=162)

*p<0.05; **p<0.01; ***p<0.001.
†number not responding or unsure not shown

Regarding perceived social norms surrounding RH, pregnancy, and infant care, female and male school-based youth agreed in several areas (Table 3.31). However, male participants were more likely to endorse men playing an active role in their communities to ensure that they and their wives obtain facility-based care during pregnancy and delivery and seek FP methods. By contrast, male participants were also significantly more likely to agree with statements that reflected community disapproval of husband's involvement in FP or birth preparedness. Female participants were more likely to agree with statements reflecting correct RMNCH information, such as safety of FP and need for four ANC visits.

Table 3.31. Perceived social norms concerning maternal, newborn, and child health and family planning among school-based youth, by sex (Afghanistan, 2017) (n=1200)

Statement	Male			Female		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree
Husbands and wives in my community use family planning to space births.	77.2% (464)***	9.5% (57)	13.3% (80)	60.4% (362)	28.4% (170)	11.2% (67)
Women in my community get care for their pregnancies from health providers before delivery.	85.4% (513)***	7.7% (46)	7.0% (42)	75.8% (454)	15.0% (90)	9.2% (55)
Women in my community give birth at health facilities.	88.7% (533)	4.8% (29)	6.5% (39)	88.2% (528)	8.7% (52)	3.2% (19)
Women in my community go to health facilities/ talk to health workers about family planning methods.	83.9% (504)**	8.8% (53)	7.3% (44)	76.8% (460)	12.0% (72)	11.2% (67)
Men in my community go to health facilities/talk to health workers about family planning methods.	72.6% (436)***	12.5% (75)	15.0% (90)	52.8% (316)	21.7% (130)	25.5% (153)
Men in my community go to health facilities/talk to health workers about antenatal care and birth planning.	72.7% (437)***	12.0% (72)	15.7% (92)	51.4% (308)	22.9% (137)	25.7% (154)
People in my community are supportive regarding family planning use.	84.5% (508)***	7.3% (44)	8.2% (49)	66.1% (396)	22.7% (136)	11.2% (67)
People in my community are supportive regarding delivering in a health facility.	89.5% (538)***	5.0% (30)	5.5% (33)	77.6% (465)	15.7% (94)	6.7% (40)
Men in my community are involved in family planning.	85.0% (511)***	8.7% (52)	6.3% (38)	68.0% (407)	19.9% (119)	12.2% (73)
Men in my community are involved in birth preparedness planning.	85.0% (511)***	8.2% (49)	6.8% (41)	68.0% (407)	21.2% (127)	10.9% (65)
I believe that frequent childbearing with short spacing between births is harmful to the health of the mother.	89.2% (536)	5.5% (33)	5.3% (32)	88.8% (532)	1.7% (10)	9.5% (57)
I believe that early (before age 18) childbearing is harmful to the health of the mother.	88.0% (529)	6.5% (39)	5.5% (33)	90.5% (542)	0.8% (5)	8.7% (52)
I believe that using family planning methods to space children is safe.	86.2% (518)*	7.8% (47)	6.0% (36)	90.0% (539)	3.8% (23)	6.2% (37)
Most family planning methods can be removed/stopped any time you want to be pregnant.	74.4% (447)	16.0% (96)	9.7% (58)	76.8% (460)	18.5% (111)	4.7% (28)

Statement	Male			Female		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree
Going to at least four ANC visits can help women have healthier babies.	90.4% (543)***	5.8% (35)	3.8% (23)	96.8% (580)	2.3% (14)	0.8% (5)
Families are more prepared for having babies if husbands are involved in their wives' family planning use.	88.4% (531)	6.3% (38)	5.3% (32)	85.3% (511)	12.2% (73)	2.5% (15)
If a woman experiences complications during delivery, she is more likely to get the help she needs at a health facility than if she gives birth at home.	88.4% (531)	8.0% (48)	3.7% (22)	89.0% (533)	8.5% (51)	2.5% (15)
Families are more likely to have healthy babies and mothers if husbands are involved in their wives' birth preparedness planning.	90.5% (544)	6.7% (40)	2.8% (17)	92.3% (553)	6.3% (38)	1.3% (8)
Families who use family planning to space their pregnancies have a better future than families who do not use family planning.	89.0% (535)***	7.3% (44)	3.7% (22)	82.1% (492)	9.5% (57)	8.3% (50)
It is difficult for women to get family planning methods.	35.6% (214)**	9.3% (56)	55.1% (331)	27.7% (166)	15.4% (92)	56.9% (341)
It is difficult for women to go to at least four antenatal visits during pregnancy.	31.5% (189)	8.7% (52)	59.9% (360)	27.4% (164)	10.5% (63)	62.1% (372)
It is difficult for pregnant women to access healthy foods.	40.1% (241)***	9.3% (56)	50.6% (304)	28.1% (168)	15.2% (91)	56.8% (340)
It is difficult for women to be able to give birth in health facilities.	28.1% (169)*	6.7% (40)	65.2% (392)	21.9% (131)	10.5% (63)	67.6% (405)
It is difficult for infants to get care in health facilities.	28.8% (173)*	10.7% (64)	60.6% (364)	23.0% (138)	12.7% (76)	64.3% (385)
My community wouldn't think it is appropriate for husbands to be involved in their wives' use of family planning methods.	45.6% (274)***	10.3% (62)	44.1% (265)	30.1% (180)	26.9% (161)	43.1% (258)
My community wouldn't think it is appropriate for husbands to be involved in their wives pregnancies.	45.1% (271)***	12.2% (73)	42.8% (257)	29.6% (177)	27.9% (167)	42.6% (255)

*p≤0.05; **p≤0.01; ***p≤0.001.

Men

Demographics

A total of 1,658 men ages 18–49 years participated in the survey; there was some overlap in age between these participants and those enrolled through the youth groups. However, we used the national age of adult consent (18 years) as the minimum age for recruiting men from organizations in which participants were involved in trade and socially acknowledged as adults. Respondents were purposively selected from the following groups: farmers' organizations (27.3 percent, n=453), community leaders (18.2 percent, n=302), the Afghan National Army (16.1 percent, n=267)

and Afghan National Police (11.0 percent, n=183)—collectively known as ANSF—and IDP communities (27.1 percent, n=450); three participants were members of a different group. Half of the respondents (51.3 percent) were sampled from sites in urban locations.

Participants' sociodemographic characteristics are presented in Table 3.32. The rationale for segmenting by marital status is that having the role of "husband and family protector" may make FP/MNCH information and decision making more relevant and may change social norms to which one must adhere. Further, marital status acts as a proxy indicator for whether men have children, as 89.0 percent of men who had ever been married reported having at least one child, and a further 11 of 24 who were married and did not have a child reported that their wives were currently pregnant. The rationale for segmenting the analysis of men by IDP status, in addition to growing populations of IDPs in Afghanistan,[20] is that the loss of a home and a change in social framework may substantially affect perspectives on information and care needs among main decision makers within families.

While a majority of respondents were married, 31.5 percent reported never having been married. Among married participants, 5.2 percent reported having more than one current wife. Most participants (93.3 percent) were born in Afghanistan, with the remainder born in Pakistan (4.5 percent), Iran (2.1 percent), and the United Arab Emirates (0.1 percent). Nearly one-quarter (23.0 percent, n=1547) of those born in Afghanistan reported that their current homes were not in their province of birth, predominantly among those identifying as IDPs (60.7 percent, $p<0.01$).

Table 3.32. Sociodemographic characteristics among men from seven provinces (Balkh, Bamiyan, Herat, Kabul, Kandahar, Nangarhar, and Takhar), by IDP and martial status (Afghanistan, 2017) (n=1,658)

Characteristic	Overall (n=1,658) mean (SD) or % (n)	Married (n=1,124) mean (SD) or % (n)	Unmarried (n=531) mean (SD) or % (n)	IDP (n=450) mean (SD) or % (n)	Non-IDP (n=1,209) mean (SD) or % (n)
Age	29.8 (±9.3)	33.6 (± 8.6)	21.8 (± 4.1)	30.9 (± 9.3)	29.4 (± 9.2)
Married	68.0 (1,127)	--	--	77.3 (348)	64.5 (779)
Have children currently†	89.0 (1,103)	89.0 (1,103)	--	88.5 (308)	89.2 (695)
IDP	27.1 (450)	30.9 (348)	19.2 (102)	--	--
Any formal education	68.2 (1,130)	59.1 (666)	87.4 (464)	53.3 (24)	73.7 (890)
Primary	21.5 (246)	26.9 (179)	12.1 (56)	29.2 (70)	18.5 (165)
Secondary	18.0 (206)	18.8 (125)	17.5 (81)	16.7 (40)	18.7 (166)
Higher	53.8 (615)	47.3 (315)	64.7 (300)	44.6 (107)	57.1 (508)
Vocational	4.9 (56)	4.8 (32)	5.2 (24)	7.1 (17)	4.4 (39)
Madrassa	1.8 (21)	2.3 (15)	0.7 (3)	2.5 (6)	1.4 (12)
Living in province of birth	77.0 (1,191)	72.9 (786)	86.4 (405)	39.3 (160)	90.4 (1,031)
Able to read full sentence*	29.6 (953)	32.3 (71)	21.1 (15)	30.6 (26)	29.1 (60)
Television in household	57.4 (953)	54.1 (610)	64.6 (343)	39.1 (176)	64.3 (777)
Radio in household	49.4 (820)	44.8 (505)	59.3 (315)	58.0 (261)	46.2 (559)
Owns mobile phone	97.9 (1,620)	97.8 (1,099)	98.2 (521)	97.3 (437)	98.1 (1,183)

*Denominator of those with any formal education; †only men ever married were asked if they have children.

Participants who reported fewer than six years of formal education were requested to read a sentence to gauge literacy (Table 3.33).

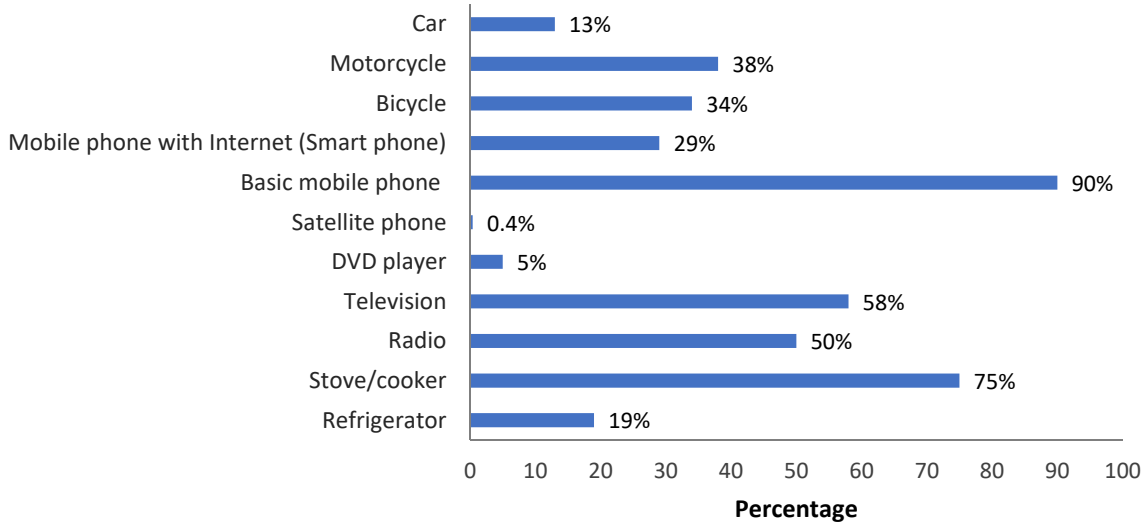
Table 3.33. Literacy level by years of education among men reporting up to six years of formal education (Afghanistan, 2017) (n=291)

Years of Education Completed	Unable to Read	Can Read Part of Sentence	Can Read Full Sentence	Visually Impaired
1 (n=10)	70%	30%	--	--
2 (n=36)	67%	19%	14%	--
3 (n=60)	40%	37%	22%	1%
4 (n=57)	40%	39%	19%	2%
5 (n=51)	24%	39%	35%	2%
6 (n=77)	17%	31%	51%	1%

Reported household water sources included dug well (17.0 percent, n=281), protected well (15.9 percent, n=263), tube well/borehole (15.5 percent), public tap (12.7 percent), piped water into dwelling (10.3 percent) or yard plot (10.1 percent), surface water (6.4 percent), unprotected spring (3.6 percent), and protected spring (3.6 percent).

Agriculture/animal rearing (37.3 percent n=618) and service/salaried (25.9 percent, n=430) were the most common sources of income, followed by day labor (18.5 percent, n=306) and business/trade (11.3 percent, n=187). A snapshot of household wealth for men is portrayed in Figure 3.21.

Figure 3.21. Household wealth indicators among adult male respondents (Afghanistan, 2017) (n=1,658)



Media Exposure

Media exposure among men is presented in Table 3.34. Three-quarters reported never having read print media or accessed the Internet. Television and radio use were more common.

Table 3.34. Media exposure among men, by IDP and marital status (Afghanistan, 2017) (n=1,658)

Media Source	Daily % (n)	At Least Weekly % (n)	Less than Weekly % (n)	Not at All % (n)
Newspapers, magazines	3.6 (55)	11.6 (179)	10.0 (155)	74.8 (1,157)
Married	2.9 (30)	9.9 (104)	8.0 (84)	79.2 (830)
Unmarried	5.0 (25)	15.1 (75)	14.3 (71)	65.7 (327)
IDP	0.9 (4)	6.6 (28)	7.3 (31)	85.1 (361)
Non-IDP	4.6 (51)	13.5 (151)	11.1 (124)	70.9 (796)
Radio	28.2 (468)	15.0 (248)	6.2 (102)	50.7 (840)
Married	28.9 (326)	13.8 (156)	5.0 (56)	52.3 (589)
Unmarried	26.7 (142)	17.3 (92)	8.7 (46)	42.3 (251)
IDP	44.9 (202)	15.6 (70)	5.8 (26)	33.8 (152)
Non-IDP	22.0 (266)	14.7 (178)	6.3 (76)	57.0 (688)
Television	44.9 (745)	9.7 (161)	4.2 (69)	41.2 (683)
Married	43.9 (495)	9.2 (104)	3.6 (40)	43.3 (488)
Unmarried	47.1 (250)	10.7 (57)	5.5 (29)	36.7 (195)
IDP	29.3 (132)	9.6 (43)	3.3 (15)	57.8 (260)
Non-IDP	50.8 (613)	9.8 (118)	4.5 (54)	35.0 (423)
Internet (n=1,653)	14.0 (232)	6.2 (102)	2.4 (40)	77.4 (1274)
Married	11.2 (127)	4.0 (45)	1.9 (22)	82.9 (942)
Unmarried	20.1 (105)	10.9 (57)	3.4 (18)	65.6 (343)
IDP	10.4 (47)	4.7 (21)	0.9 (4)	84.0 (378)
Non-IDP	15.3 (185)	6.7 (81)	3.0 (36)	75.0 (907)

Among those reading print media, the most common topics were news and current events (63.8 percent), political or religious commentary (38.3 percent), and sports (21.3 percent). Married men were significantly more likely to read news and current events (p=0.019); there was no significant difference by IDP status. Nearly one-third (29.3 percent) of men reported reading about a health topic in the past month, the most common being immunization (41.2 percent), handwashing/hygiene (25.4 percent), and nutrition (21.1 percent). Male IDPs were significantly more likely than non-IDPs to have read about a health topic in the past month (42.9 percent versus 26.7 percent, p=0.010); no difference was observed by marital status.

Figure 3.22. Most frequent radio and TV viewing times reported by men, by marital status, Afghanistan 2017 (n=716 radio listeners; n=906 TV viewers)

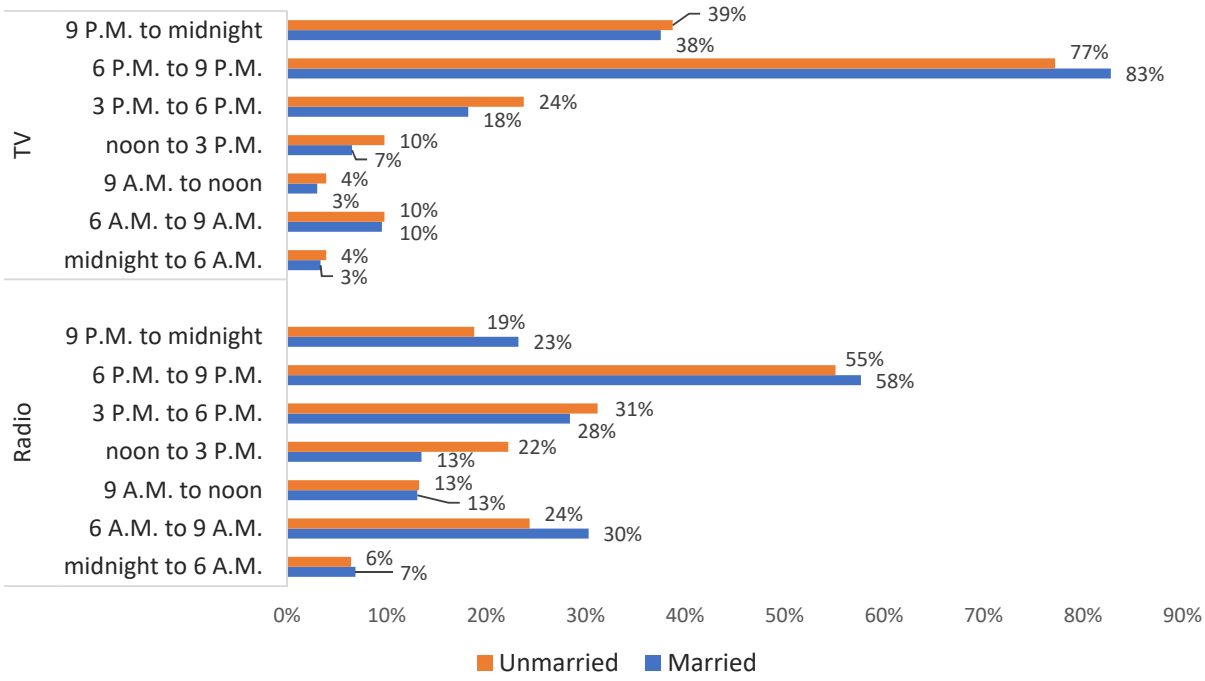


Figure 3.22 shows the most common time intervals for listening to the radio or watching television.

Men's likelihood of listening to the radio at least weekly was significantly associated with younger age (29.0 years versus 30.4 years, p=0.002), IDP status (60.4 percent versus 36.7 percent, p<0.001), and province (p<0.001). Provincial distribution of reported weekly radio use follows: Balkh (38.0 percent), Bamyan (39.1 percent), Herat (21.9 percent), Kabul (43.2 percent), Kandahar (60.7 percent), Nangarhar (70.6 percent), and Takhar (26.5 percent). Men reported listening primarily to national news (77.2 percent), international news (56.3 percent), local news (47.2 percent), and music (30.6 percent). Popular radio stations were Azadi, BBC, Shamshad, En-ekas, Sharq, and Bamiyan. Of all radio listeners, 37.7 percent reported listening to a health program in the past month, with topics including immunization (55.8 percent), hygiene/ handwashing (27.9 percent), or FP (21.8 percent).

Men who reported watching television at least weekly were more likely than those who did not to have ever attended school (63.9 percent versus 34.8 percent, p<0.001), were non-IDPs (60.5 percent versus 38.9 percent, p<0.001), report a higher mean income (11,645 Afs versus 10,300 Afs, p=0.05), and reside in Herat or Bamyan Provinces (78.1 percent in Herat and 71.2 percent in Bamyan, p<0.001); no difference was observed by marital status. Among those reporting watching television at least weekly, national news (79.9 percent), international news (58.4 percent), local news (57.1 percent), and dramas (46.1 percent) were the most commonly viewed programs. Non-IDP (p<0.001 for both comparisons) and married (p<0.001 and p=0.004, respectively) men were significantly more likely to watch national and international news. The most frequently viewed television stations were Tolo (n=592), Shamshad (n=216), Lemar (n=200), Ariana (n=117), Negah (n=114), Khursheed (n=110), Tamadon (n=68), and BBC News (n=67). Almost half (46.8 percent) of those who had watched television in the past week reported seeing programming about a health issue. IDP men were significantly more likely than non-IDPs to have seen a program about health issues in the past 30 days (59.4 percent versus 43.8 percent, p<0.001); no difference was observed by marital status. Vaccination (43.2 percent), FP (36.1 percent), and handwashing/hygiene (28.1 percent) were the most common health topics viewed on television.

Almost all men (97.9 percent) reported having their own mobile phones. Of those with no personal mobile phone (n=35), the majority (68.6 percent) reported being able to use a relative's or friend's phone. Mobile phone ownership was significantly more likely for those with any formal education than for those without (98.7 percent versus 96.2 percent, p=0.001); differences were not significant by marital status, age, monthly household income, IDP status, or urban versus rural residence.

Of 379 men (75.5 percent) reporting ever using the Internet, 61.2 percent (n=232) reported daily and 26.9 percent (n=102) reported at least weekly use; there were no significant differences by IDP or marital status. Reasons for Internet use included e-mail and social media (75.9 percent), current events (35.0 percent), sports (28.9 percent), entertainment (25.4 percent), and political/ religious commentary (23.5 percent). Approximately one-third (35.3 percent) of regular users reported consulting the Internet for health issues in the past month, most frequently searching information about nutrition (28.0 percent), handwashing/ hygiene (24.2 percent), and immunization (19.7 percent). Other topics searched by 56 respondents varied widely: hair loss, general health, and skin care were those most frequently mentioned. Consulting the Internet about health in the past 30 days was significantly associated with IDP status (51.4 percent for IDP versus 31.5 percent for non-IDP, p=0.001) but not with marital status.

Health Service-seeking Behavior

More than one-third (39.6 percent, n=549) of respondents reported receiving care from a health provider in the past six months. Utilizing health services was significantly associated with IDP status (45.6 percent for IDP versus 37.4 percent for non-IDP, $p < 0.01$), urban residence (42.0 percent for urban versus 37.1 percent for rural, $p < 0.05$), any formal education (41.5 percent for education versus 35.6 percent for none, $p < 0.05$), and higher household income (12475 Afs versus 10143 Afs, $p < 0.001$); there were no significant differences in health-seeking behavior by marital status or age. Most men (83.6 percent) received counseling from the provider at their visit. Counseling topics covered by health providers are presented in Table 3.35; health maintenance (e.g., diet, exercise) was the most common.

Table 3.35. Counseling topics received by men who sought health care services from a provider in the past six months, by IDP and marital status (Afghanistan, 2017) (n=549)

Topic	Overall (n=549)	IDP (n=185)	Non-IDP (n=364)	Married (n=379)	Unmarried (n=170)
Health maintenance	43.9% (241)	47.6% (88)	42.0% (153)	45.0% (171)	41.4% (70)
Smoking cessation	8.4% (46)	14.6% (27)	5.2% (19)	7.9% (30)	9.4% (16)
Accident prevention	6.4% (35)	6.5% (12)	6.3% (23)	6.3% (24)	6.5% (11)
Stress reduction	12.4% (68)	18.4% (34)	9.3% (34)	13.5% (51)	10.0% (17)
Depression/mental health	4.6% (25)	9.7% (18)	4.4% (16)	5.5% (21)	7.7% (13)
Family planning	4.6% (25)	4.9% (9)	4.4% (16)	5.0% (19)	3.5% (6)
Women's health	10.4% (57)	15.7% (29)	7.7% (28)	12.4% (47)	5.9% (10)
Child health	16.2% (89)	23.8% (44)	12.4% (45)	18.7% (71)	10.6% (18)
Other	44.1% (242)	30.3% (56)	51.1% (186)	42.7% (162)	47.1% (80)

Health care providers were most frequently cited (67.1 percent) as the usual source for health information; this was significantly more likely for married than unmarried men (69.6 percent versus 61.8 percent, p=0.002), and there was no difference by IDP status. CHWs (26.1 percent) were mentioned next most frequently, with non-IDP men significantly more likely than IDP men to mention them (29.1 percent versus 18.2 percent, p<0.001), and there was no difference by marital status. Just 10 percent of men mentioned family members as the usual source; this was significantly more likely for IDP than for non-IDP men (15.3 percent versus 9.1 percent, p<0.001) and, marginally, for unmarried than for married men (12.8 percent versus 9.9 percent, p=0.07). We did not inquire which family members were sources.

About one-third (29.5 percent) of men received messages in the past 12 months about the health benefits of delaying marriage, while 38.3 percent and 34.9 percent reported receiving information about child health (including nutrition) and FP/birth spacing, respectively. Doctors were the primary source of all topics, with no significant differences by IDP or marital status. The next most common information sources were television (for delaying marriage and FP) and CHWs (for child health) (Table 3.36).

Table 3.36. Sources of information about delaying marriage, child health, and family planning among men who received messages about these topics in the past 12 months, by IDP and marital status (Afghanistan, 2017) (n= 485-632; top three sources in bold type)

Topic	Overall % (n)	IDP % (n)	Non-IDP % (n)	Married % (n)	Unmarried % (n)
Delaying marriage	**(n=485)**	**(n=156)**	**(n=329)**	**(n=353)**	**(n=132)**
Health care provider	53.2% (258)	59.6% (93)	50.2% (165)	57.5% (203)	41.7% (55)
Television	**21.2% (103)**	18.0% (28)	**22.8% (75)**	**17.7% (62)**	**31.1% (41)**
CHW	**18.1% (88)**	14.7% (23)	**19.8% (65)**	**19.6% (69)**	14.4% (19)
Family member	13.2% (64)	**25.0% (39)**	7.6% (25)	13.0% (46)	13.6% (18)
Friend	12.6% (61)	**23.7% (37)**	7.3% (24)	9.6% (34)	**20.5% (27)**
Radio	7.2% (35)	6.4% (10)	7.6% (25)	5.4% (19)	12.1% (16)
Religious leader	2.5% (12)	2.6% (4)	2.4% (8)	2.8% (10)	1.5% (2)
Village leader	1.2% (6)	2.6% (4)	0.6% (2)	1.1% (4)	1.5% (2)
Child health	**(n=632)**	**(n=158)**	**(n=474)**	**(n=426)**	**(n=206)**
Health care provider	48.1% (304)	58.2% (92)	44.7% (212)	54.0% (230)	35.9% (74)
Television	**20.3% (128)**	16.5% (26)	**21.5% (102)**	**19.5% (83)**	**21.8% (45)**
CHW	**20.9% (132)**	13.3% (21)	**23.4% (111)**	**20.9% (89)**	**20.9% (43)**
Family member	14.9% (94)	**24.1% (38)**	11.8% (56)	12.2% (52)	20.4% (42)
Friend	9.2% (58)	**21.5% (34)**	5.1% (24)	7.5% (32)	12.6% (26)
Radio	9.0% (57)	11.4% (18)	8.2% (39)	7.8% (33)	11.7% (24)
Religious leader	3.2% (20)	4.4% (7)	2.7% (13)	2.8% (12)	3.9% (8)
Village leader	0.6% (4)	0.0% (0)	0.8% (4)	0.7% (3)	0.5% (1)
Family planning/birth spacing	**(n=575)**	**(n=137)**	**(n=438)**	**(n=399)**	**(n=176)**
Health care provider	42.3% (243)	53.3% (73)	38.8% (170)	49.6% (198)	25.6% (45)
Television	37.4% (215)	32.1% (44)	39.0% (171)	36.1% (144)	40.3% (71)
CHW	14.6% (84)	8.0% (11)	**16.7% (73)**	16.0% (64)	11.4% (20)
Family member	9.2% (53)	20.4% (28)	5.7% (25)	7.5% (30)	13.1% (23)
Friend	**16.0% (92)**	**24.1% (33)**	13.5% (59)	12.5% (50)	**23.9% (42)**
Radio	6.4% (37)	6.6% (9)	6.4% (28)	5.5% (22)	8.5% (15)
Religious leader	2.4% (14)	3.7% (5)	2.1% (9)	3.3% (13)	0.6% (1)
Village leader	1.0% (6)	0.7% (1)	1.1% (5)	1.5% (6)	0.0% (0)

Men were also asked which sources of information on delaying marriage, child health, and FP they perceived to be most convenient and most accurate (Figures 3.23 and 3.24).

Figure 3.23. Information sources for selected topics perceived most accurate and most convenient among men, by marital status (Afghanistan, 2017) (n=485 – 632)

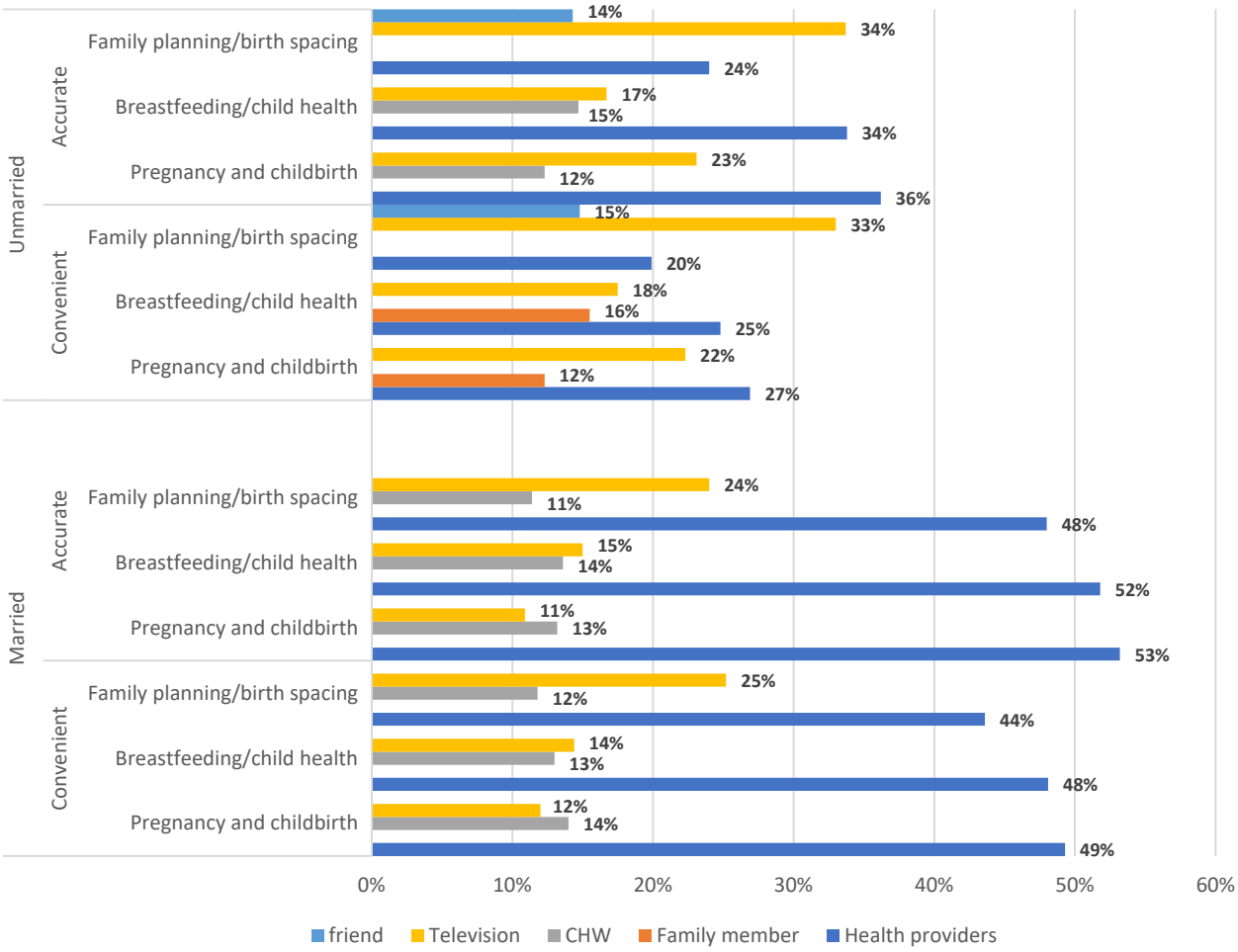
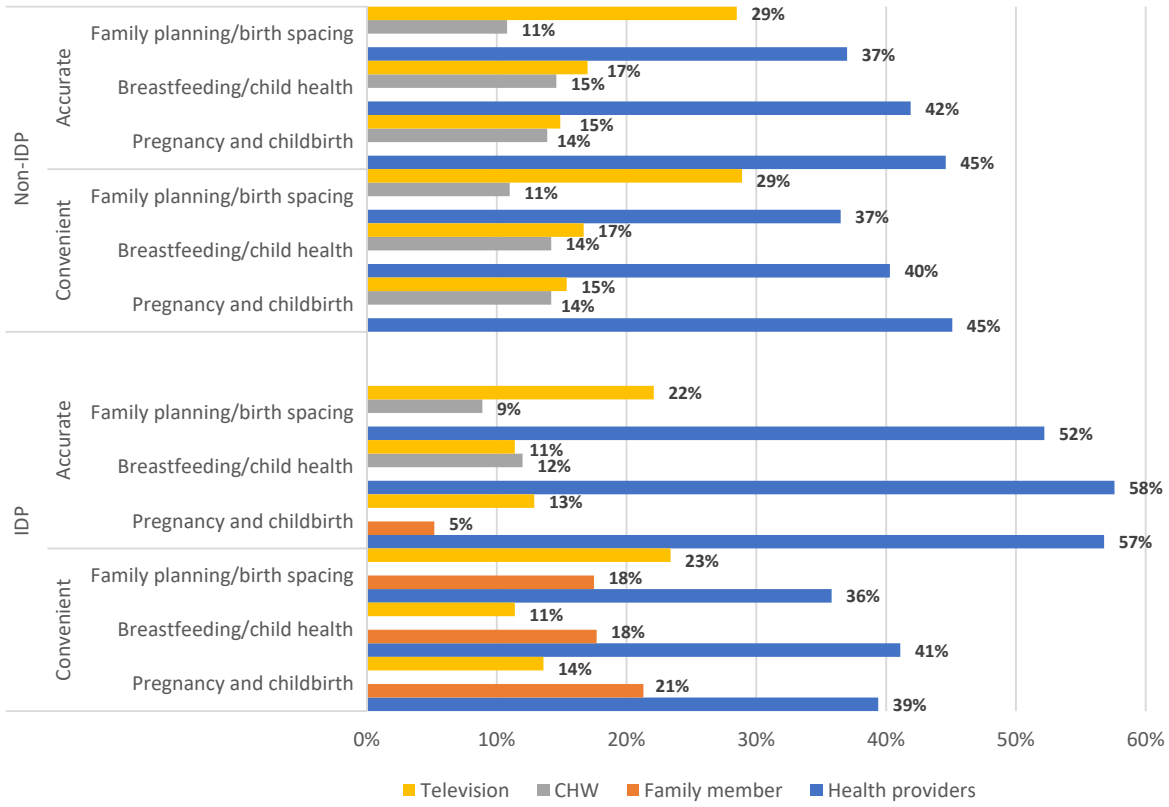


Figure 3.24. Information sources for selected topics perceived most accurate and most convenient among men, by IDP status (Afghanistan, 2017) (n= 485 - 632)



Nearly all men indicated the desire for more health information. We asked what topics were of greatest interest, and men could name as many topics as they wanted (unprompted). Main topics from 1,571 respondents were nutrition and feeding the family (29.9 percent), care during pregnancy (29.6 percent), newborn care (29.1 percent), care during childbirth (20.2 percent), and breastfeeding and infant feeding practices (19.5 percent). Respondents also mentioned other topics (35.7 percent), including general health/disease prevention (30.5 percent) and sanitation/ hygiene (6.3 percent).

Maternal and Child Health Knowledge

Men's knowledge surrounding ANC and associated risks and complications of pregnancy and delivery, is presented in Table 3.37. While most respondents correctly agreed with statements regarding the importance of ANC visits, respondents were less sure of specific pregnancy and delivery risks women faced. There was less agreement about the need for ANC visits when feeling well among IDP than non-IDP men (83.8 percent versus 89.7 percent, $p<0.001$) and among participants from Nangarhar (69.6 percent) or Balkh (80.0 percent) when compared with those from other provinces (90.7 percent to 96.7 percent, $p<0.001$).

Table 3.37. Knowledge of antenatal care, pregnancy complications, and labor/delivery risks among men, by marital and IDP status (Afghanistan, 2017) (n=1,658)

Maternal Health Statement	Overall (n=1,658)		IDP (n=450)		Non-IDP (n=1,205)		Married (n=1,127)		Unmarried (n=528)	
	%	n	%	n	%	n	%	n	%	n
Pregnant women should have ANC visits even if they feel well	88.1	1,458	83.8	377	89.7	1,081	89.1	1,004	86.0	454
Pregnant women should have at least four ANC visits	93.6	1,546	91.3	408	94.5	1,138	94.7	1,064	91.5	482
Serious conditions that could be life-threatening during pregnancy										
At least one condition identified	64.1	1,062	59.8	269	65.7	793	68.9	777	53.7	285
Bleeding	42.4	450	39.1	97	44.5	353	44.9	349	35.4	101
Severe headache	16.3	173	23.8	64	13.8	109	16.1	125	16.8	48
Severe weakness	24.6	261	37.2	100	20.3	161	25.9	201	21.1	60
Loss of consciousness	13.5	143	26.4	71	9.1	72	14.4	112	10.9	31
Severe abdominal pain	12.3	131	20.1	54	9.7	77	10.9	85	16.1	46
Swollen hands/face	9.3	99	11.2	30	8.7	69	10.8	84	5.3	15
Fever	7.0	74	10.4	28	5.8	46	7.7	60	4.9	14
Blurred vision	7.2	76	13.9	40	4.5	36	7.0	54	7.7	22
Convulsions	7.3	77	14.1	38	4.9	39	6.8	53	8.4	24
Difficulty breathing	9.9	105	18.6	50	6.9	55	10.7	83	7.7	22
Premature rupture of membranes	4.4	47	9.7	26	2.7	21	4.5	35	4.2	12
Reduced fetal movement	5.8	62	5.6	15	5.9	47	5.9	46	5.6	16
Other condition	35.3	375	17.5	47	41.4	328	34.0	264	39.0	111
No response	1.0	27	3.1	14	0.4	5	1.3	15	0.8	4
Do not know	34.9	578	37.1	167	34.2	413	29.9	337	45.8	243
Potential complications during labor and delivery										
Severe bleeding	44.1	718	38.5	167	46.1	551	49.2	542	33.4	176
Loss of consciousness	12.6	205	21.2	92	9.5	113	13.6	150	10.4	55
High fever	10.5	171	10.7	90	6.8	81	10.5	116	10.4	55
Convulsions	8.5	138	18.0	78	5.0	60	8.6	95	8.3	43
Prolonged labor (>12 hours)	12.2	198	10.6	46	12.7	152	13.4	148	9.5	50
Baby in wrong position/ malpresentation	14.9	242	16.1	70	14.4	172	17.4	192	9.5	50
Placenta not delivered within 30 minutes of birth	6.5	105	6.5	28	6.4	77	7.7	85	3.8	20
Other condition	11.0	180	5.3	23	13.1	157	11.8	130	9.5	50
Do not know	35.9	584	39.9	173	34.8	416	30.4	335	48.2	254

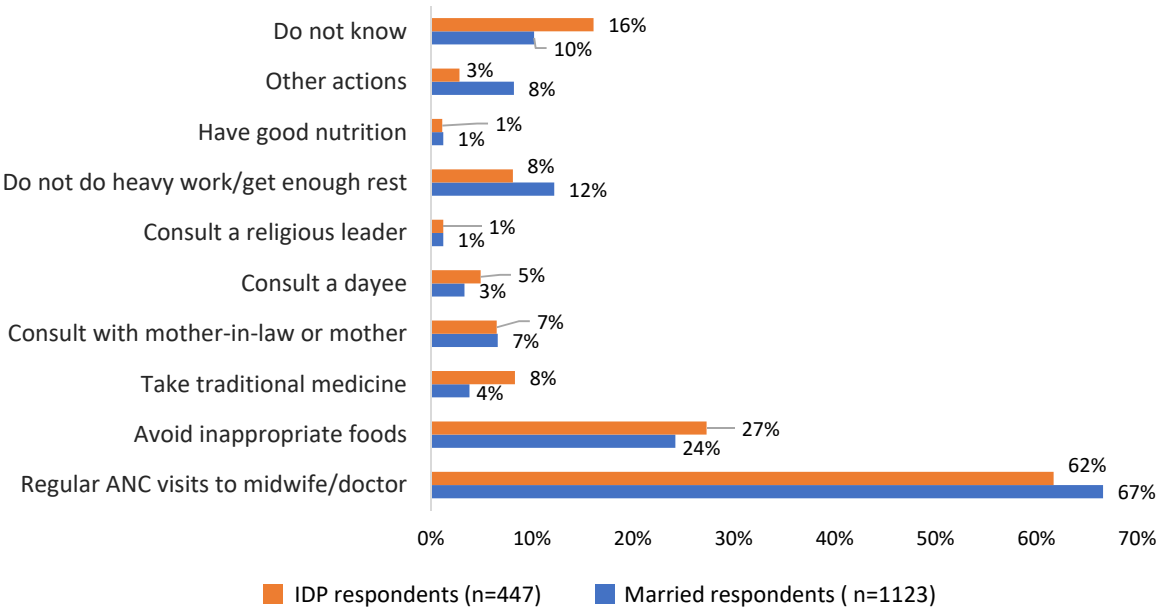
Men were asked an open-ended question about what they would do if their wife experienced a pregnancy complication; 8.3 percent did not respond and 0.2 percent stated no action was necessary. Most men (92.7 percent) stated they would take their wife to a health facility, which was more likely among non-IDP than IDP men (94.6 percent versus 87.2 percent, $p<0.001$) and among those with any formal education than those without (94.3 percent versus 89.2 percent, $p<0.001$). Other common responses were purchasing medicine (6.1 percent), seeking help of a *dayee* (i.e., traditional birth attendant) (7.0 percent) or relative

(5.9 percent), or seeing a religious leader or mullah for *taweez* (i.e., amulets) or prayers (1.7 percent). Purchasing medicine was more likely to be mentioned by IDP than non-IDP men (9.0 percent versus 5.1 percent, p=0.007) and by those with any formal education than those without (8.1 percent versus 5.2 percent, p=0.03), while seeking help of a *dayee* was more likely to be mentioned by older than younger men (mean age 32.0 years versus 30 years, p=0.004) and by IDP than non-IDP men (10.7 percent versus 5.7 percent, p=0.002). Married men were more likely than unmarried men to list seeking help from relatives (6.7 percent versus 4.2 percent, p=0.05). Reported monthly income was not associated with any reported action. In multivariable analysis, men who stated they would go to a health facility if their wife had a pregnancy complication were more likely to have any formal education than to have none (AOR=1.67, 95 percent CI: 1.12–2.49) and less likely to be IDPs than non-IDPs (AOR=0.43, 95 percent CI: 0.29–0.64). In multivariable logistic regression analysis with fitting for the most parsimonious model, only IDP status remained significantly independently associated with procuring medicines or seeking the help of a *dayee*.

Many men (62.5 percent) acknowledged that women could die from pregnancy complications, though nearly one-third (32.1 percent, n=521) did not know the answer to this question. Married when compared to unmarried men (72.1 percent versus 57.7 percent, p<0.001) and IDP when compared to non-IDP men (68.6 percent versus 60.2 percent, p=0.002) were significantly more likely to know that women could die from pregnancy complications. Most men (87.2 percent) stated that women who become pregnant before age 18 years face a greater risk of pregnancy complications than women ages 18–34 years; notably, unmarried when compared to married men (89.8 percent versus 85.9 percent, p=0.025) and non-IDP when compared to IDP men (90.2 percent versus 78.9 percent, p<0.001) were significantly more likely to acknowledge this risk.

To best prepare for birth, men responded that women and their families should go to a health facility (69.2 percent), save money (20.7 percent), and identify transportation to the health facility for delivery (18.1 percent). Actions families can take to reduce health risks during pregnancy, as reported by married men and IDP men, are presented in Figure 3.25. Married when compared to unmarried men (24.2 percent versus 18.0 percent, p=0.005) and IDP when compared to non-IDP men (27.3 percent versus 20.4 percent, p=0.003) were significantly more likely to state avoiding inappropriate foods.

Figure 3.25. Actions families can take to reduce health risks during pregnancy according to adult male respondents (Afghanistan, 2017) (n=1570)



Most respondents (90.2 percent) identified health facilities as the best place for women to deliver. The main reasons were better care (91.8 percent), safety (66.4 percent), and ease of access (33.1 percent). Among those who preferred home delivery, respondents mentioned privacy (40.5 percent), lower expense (25.3 percent), and tradition (24.1 percent) as primary reasons. Table 3.38 presents bivariate associations for preferring facility-based delivery with different sociodemographic characteristics.

Table 3.38. Correlates of preferring facility-based delivery among adult male respondents, by marital and IDP status (Afghanistan, 2017) (n=1496)

Variable	Married	Unmarried	IDP	Non-IDP
	% (n)	% (n)	% (n)	% (n)
Age, mean (±SD)	33.9 (8.6) vs. 30.7 (8.6)**	21.7 (3.5) vs. 20.8 (3.7)	30.8 (9.4) vs. 31.7 (8.8)	29.8 (9.2) vs. 24.3 (7.2)***
Mean monthly income in Afs (±SD)	9,587 (8,662) vs. 2,587 (15,010)	13,295 (11298) vs. 24,167 (48834)**	10,329 (9739) vs. 8,187 (5295)	10,899 (9,816) vs. 18,471 (38,008)***
Province	***	**	***	
Balkh	96.8 (120)	85.2 (23)	---	---
Bamyan	96.6 (201)	97.0 (91)	---	---
Herat	92.7 (51)	82.1 (78)	---	---
Kabul	80.7 (134)	84.4 (114)	78.8 (119)	86.0 (129)
Kandahar	96.8 (93)	98.2 (53)	97.3 (142)	---
Nangarhar	81.9 (204)	90.7 (49)	78.4 (120)	88.7 (143)
Takhar	94.9 (224)	93.9 (61)	---	---
Residence				**
Urban	89.4 (444)	88.6 (313)	86.3 (167)	90.2 (543)
Rural	91.4 (583)	91.9 (156)	82.7 (214)	94.4 (572)
IDP status	***		--	--
IDP	81.9 (286)	94.1 (95)		
Non-IDP	94.4 (741)	88.6 (374)		
Any formal education	***	**	***	
Yes	93.1 (623)	91.1 (420)	90.8 (218)	92.7 (825)
No	86.7 (404)	79.0 (49)	77.6 (163)	91.2 (290)

*p<0.05; **p<0.01; ***p<0.001.

Newborn Care

Men often answered incorrectly or reported not knowing the answers to open-ended questions related to umbilical cord care, timing of breastfeeding initiation, and duration of exclusive breastfeeding and complementary feeding. Further, while most men (94.3 percent) stated that breast milk alone was better for infants under six months of age, only half correctly identified the recommended durations of exclusive breastfeeding (54.3 percent) and complementary feeding (52.3 percent). Married men were more likely than their unmarried counterparts to know the correct answers to these questions in most cases; however, only about half (or fewer) of married men provided correct responses (Table 3.39).

Table 3.39. Knowledge of newborn care, including appropriate cord care, newborn temperature regulation, and initiation of breastfeeding among men, by marital and IDP status (Afghanistan, 2017) (n=1,658)

Newborn Health Statement	Married	Unmarried	IDP	Non-IDP
	% (n)	% (n)	% (n)	% (n)
Appropriate cord care				
Keep cord dry	23.4 (262)	14.7 (78)	23.5 (104)	19.5 (236)
CHX daily for one week	26.4 (295)	17.7 (94)	26.9 (119)	22.4 (270)
Apply something else to the cord stump (e.g., ghee, ash)	23.2 (259)	20.3 (108)	17.2 (76)	24.1 (291)
Other action (e.g., get advice of doctor, keep it clean)	12.6 (141)	11.9 (63)	7.9 (35)	14.0 (169)
Do not know	30.5 (341)	44.1 (234)	36.9 (163)	34.1 (412)
Best way to regulate newborn's body temperature				
Wrap/swaddle the baby	51.7 (580)	45.1 (239)	54.0 (241)	47.9 (578)
Put hat on baby's head	18.4 (207)	14.9 (79)	26.7 (119)	13.8 (167)
Make sure room is warm	42.3 (475)	46.8 (248)	27.6 (123)	49.7 (600)
Keep baby wrapped on mother's chest	9.5 (107)	8.9 (47)	17.5 (78)	6.3 (76)
Delay bathing the baby	8.1 (91)	4.7 (25)	14.4 (64)	4.3 (52)
Other action (e.g., wearing warm clothes, washing baby)				
Do not know	14.6 (164)	15.3 (81)	17.3 (77)	13.9 (168)
When to initiate breastfeeding				
Within one hour of birth	49.6 (558)	40.8 (216)	49.2 (221)	45.9 (553)
Within several hours of birth	20.4 (230)	21.7 (115)	22.9 (103)	20.1 (242)
Within one day	6.4 (72)	6.8 (36)	6.2 (28)	6.6 (80)
Within several days	2.5 (28)	2.7 (14)	2.5 (11)	2.6 (31)
When the white milk comes in	3.8 (43)	3.8 (20)	5.1 (23)	3.3 (40)
Do not know	17.3 (195)	24.2 (128)	14.0 (63)	21.6 (260)

CHX knowledge was generally higher among married than unmarried men and among IDP than non-IDP men (Table 3.40). In both bivariate and multivariable analysis, participants from Kandahar and participants who were older or had used the Internet were more likely than others to have CHX knowledge, while men from Bamyan and Kabul were less likely than others to have this knowledge. Generally, exposure to mass media channels was not associated with CHX knowledge.

Table 3.40. Correlates of knowledge of chlorhexidine use for umbilical cord care among adult male respondents, by marital and IDP status (Afghanistan, 2017) (n=1,650)

Variable	Married (n=1,127)	AOR (95% CI)	Unmarried (n=523)	AOR (95% CI)	IDP (n=442)	AOR (95% CI)	Non-IDP (n=1,208)	AOR (95% CI)
Overall %	26.3***	---	17.8	---	26.9*	---	22.4	---
Age, mean±SD	34.1±8.0 vs. 33.4± 8.8	1.02 (1.00–1.04)	22.2 ± 3.6 vs. 21.5± 3.4		30.0±8.3 vs.31.2± 9.7		31.9±9.2 vs. 28.7± 9.2***	1.05 (1.03–1.07)
Province	***		***		***		***	
Balkh	29.0	0.96 (0.59–1.55)	11.1		---		25.8	Ref
Bamyan	14.4	0.40 (0.25–0.64)	13.8	0.54 (0.22–1.33)	---		14.2	0.47 (0.28–0.78)
Herat	32.7	1.23 (0.65–2.33)	23.2	1.05 (0.46–2.41)	---		26.7	1.35 (0.77–2.39)
Kabul	8.4	0.24 (0.13–0.45)	1.5	0.06 (0.01–0.28)	8.7	0.21 (0.11–0.41)	2.0	0.09 (0.03–0.32)
Kandahar	36.7	1.53 (0.91–2.57)	51.9	3.94 (1.67–9.28)	43.6	1.63 (0.99–2.69)	---	---
Nangarhar	37.5	1.61 (1.09–2.38)	20.4	Ref	29.6	Ref	39.3	2.27 (1.35–3.81)
Takhar	30.5	Ref	21.5	0.90 (0.36–2.23)	---		28.6	1.11 (0.70–1.77)
IDP	26.0 vs. 26.4		30.0 vs. 4.9***		---		---	
Any formal education	29.4 vs. 21.7*	1.69 (1.25–2.30)	18.7 vs. 11.3		29.1 vs. 24.4		23.9 vs. 17.9*	1.70 (1.17–2.46)
Prior Internet use	32.0 vs. 24.6*		23.3 vs. 13.3**	1.66 (1.00–2.75)	39.2 vs. 23.5**	2.11 (1.23–3.62)	25.2 vs. 21.1	
View television at least weekly	27.6 vs. 24.7		17.1 vs. 18.7		27.6 vs. 26.5		23.3 vs. 21.0	
Listen to radio at least weekly	27.5 vs. 25.3		17.8 vs. 17.7		28.6 vs. 24.3		21.8 vs. 22.6	
Seen health provider in last 6 months	24.8 vs. 27.2		18.0 vs. 17.6		21.3 vs. 31.7*	0.44 (0.35–0.79)	23.2 vs. 21.8	

*p<0.05; **p<0.01; ***p<0.001; †analysis adjusted by age.

Married respondents were significantly more likely than their unmarried counterparts to know to initiate breastfeeding within one hour of birth (49.5 percent versus 40.7 percent, p=0.001); no difference was observed by IDP status. Among married men, correct knowledge of breastfeeding initiation was significantly associated with being older (mean age, 34.5 years for those who had correct knowledge versus 32.7 years for those who did not, p<0.001) and having any formal education (52.6 percent for those with education versus 45.1 percent for those without, p=0.014).

When asked about duration of exclusive breastfeeding, just over half (54.3 percent, n=899) of participants correctly responded six months. Married when compared to unmarried men (57.9 percent versus 46.5 percent, p<0.001) and non-IDP when compared to IDP men (56.2 percent versus 48.9 percent, p=0.008) were more likely to have correct knowledge. Figures 3.26 and 3.27 present knowledge of exclusive breastfeeding duration among married and IDP respondents.

Figure 3.26. Knowledge of exclusive breastfeeding duration among married men (Afghanistan, 2017) (n=1,126)

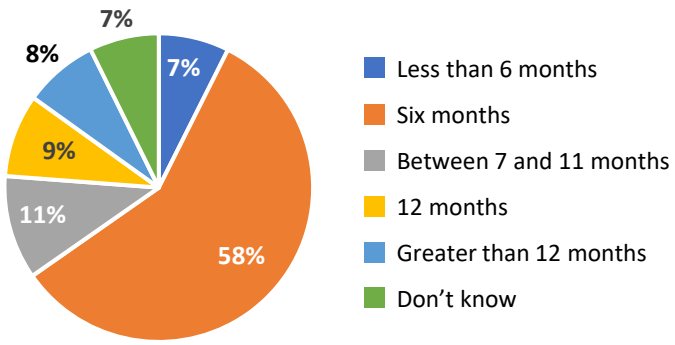
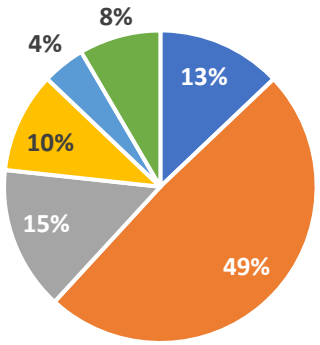


Figure 3.27. Knowledge of exclusive breastfeeding duration among IDP men (Afghanistan, 2017) (n=450)



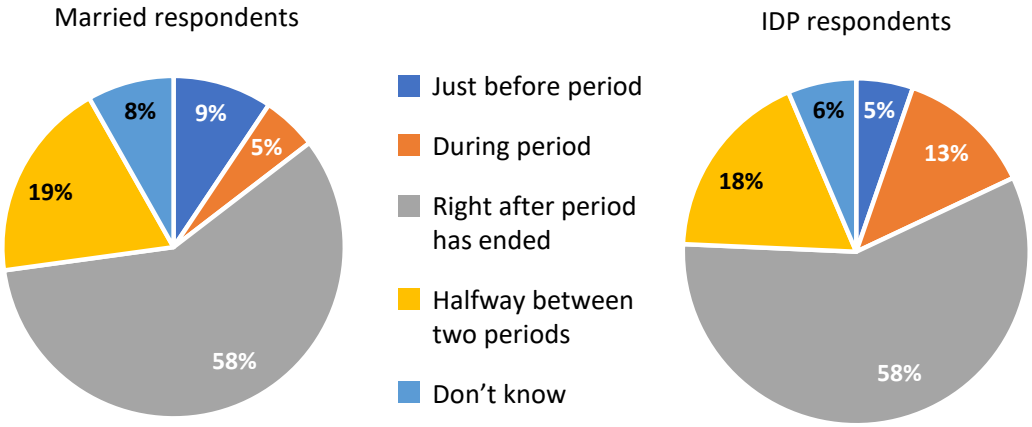
Among married men, correct exclusive breastfeeding duration knowledge was more likely among older men (34.3 years versus 32.6 years, p<0.001), those who had ever attended school (64.0 percent versus 49.0 percent, p<0.001), and non-IDP men (63.3 percent versus 45.7 percent, p<0.001). Among IDPs, any formal education (56.7 percent versus 40.0 percent, p<0.001) and having sought health care in the past six months (55.6 percent versus 43.3 percent, p=0.009) were associated with correct knowledge.
Half (52.1 percent) of men knew the correct 24 month duration for breastfeeding as part of complementary feeding, with married (56.4 percent versus 42.8 percent, p<0.001) and non-IDP (53.8 percent versus 47.6 percent, p=0.02) participants significantly more likely to have correct knowledge. Among married men, having any formal education (59.0 percent versus 52.8 percent, p=0.03) rural residence (51.1 percent versus 38.8 percent, p=0.007), and living in Takhar (66.9 percent) or Nangarhar (62.7 percent, p<0.001 for province comparison) were associated with greater knowledge of duration for breastfeeding during complementary feeding in bivariate analysis. Among non-IDPs, higher levels of knowledge of sustained breastfeeding duration was associated with living in Takhar (64.5 percent) or Nangarhar (66.0 percent, p<0.001 for all province comparison), being older (mean age, 30.8 years versus 27.7 years, p<0.001), watching television at least weekly (57.6 percent versus 48.2 percent, p=0.001), and rural residence (63.5 percent versus 44.2 percent, p<0.001) in the same analysis.

Fertility Awareness and Family Planning

Only one-third (32.9 percent, n=545) of men were aware that fertility increases during certain phases of the menstrual cycle, while 50 percent (n=829) did not know whether there were certain days when women were more fertile. Married and IDP respondents were significantly more likely than their respective counterparts to know that fertility increases during certain phases of the menstrual cycle (38.2 percent

for married versus 21.7 for unmarried, p<0.001 and 42.4 percent for IDP versus 29.3 percent for non-IDP, p<0.001). Of those married men and IDP respondents who had knowledge of peak fertility, 58.0 percent of both groups correctly responded that peak fertility occurs just after menstruation (Figure 3.28).

Figure 3.28. Knowledge of peak fertility among married and IDP men in Afghanistan, 2017 (n=545)



In bivariate analyses, residing in an urban area was found to be significantly associated with knowledge of peak fertility for both married respondents (25.8 for married versus 14.1 percent for unmarried, p=0.002) and IDP respondents (26.5 for IDP versus 8.1 for non-IDP, p=0.001); no other sociodemographic variables were associated with this knowledge of among married or IDP respondents.

More than one-quarter (26.8 percent, n=445/1,658) of men reported never having heard of FP methods, and 7.4 percent (n=123/1,658) declined to respond to this question. Married as compared to unmarried (68.2 percent versus 60.6 percent, p=0.003) and non-IDP as compared to IDP (68.7 percent versus 57.8 percent, p<0.001) respondents were significantly more likely have heard of FP methods. Of the 65.7 percent of men (n=1,090) who reported FP method awareness, oral contraceptives (82.7 percent), injectables (74.8 percent), and male condoms (63.5 percent) were the most frequently mentioned methods overall and by married men and IDP and non-IDP respondents.

Associations between awareness of specific methods and key sociodemographic variables is displayed in Table 3.41. Few participants mentioned withdrawal (7.8 percent), female (3.1 percent) and male (1.6 percent) sterilization, natural FP/Standard Days Method (1.4 percent), LAM (0.8 percent), and emergency contraception (0.2 percent); thus, we conducted no bivariate comparisons for these methods. Questions about FP knowledge often elicited a "do not know" or incorrect response from men. More than half (52.2 percent) of male participants did not know for how many months exclusive breastfeeding can be an effective FP method (LAM); no difference was observed by marital status, though non-IDPs were significantly more likely than IDPs to cite not knowing (56.5 percent versus 40.7 percent, p<0.001). Among respondents who provided an answer, only 28.5 percent (n=216/758) correctly identified six months as the maximum duration of LAM efficacy; correct knowledge of maximum LAM duration did not differ by marital status, though IDPs were significantly more likely than non-IDPs to cite six months (47.1 percent versus 19.0 percent, p<0.001).

Table 3.41. Associations between awareness of specific family planning methods and key sociodemographic characteristics among men, by marital and IDP status (Afghanistan, 2017) (n=1,090)†

Family Planning Method	Overall Awareness		IDP vs. Non-IDP	Urban vs. Rural	Any Formal Education vs. No Education	Age of Those Able vs. Unable to Name a Method
	%	n	%	%	%	Mean age, years
IUCD						
Married	9.1	*70*	6.1 vs. 10.1	8.9 vs. 9.3	10.9 vs. 5.7*	33.8 vs. 33.1
Unmarried	4.4	14	4.8 vs. 4.3	2.4 vs. 8.1*	4.4 vs. 4.8	23.1 vs. 22.0
IDP	5.8	15	--	3.5 vs. 10.2*	8.1 vs. 2.0*	30.8 vs. 28.1
Non-IDP	8.3	69	--	7.7 vs. 8.8	8.6 vs. 7.5	30.1 vs. 32.2
Male condoms						
Married	63.5	488	54.6 vs. 66.6**	62.1 vs. 65.7	70.6 vs..50.0***	34.8 vs. 33.1**
Unmarried	63.4	201	74.6 vs. 60.6*	60.2 vs. 69.4	63.2 vs. 66.7	22.5 vs. 21.2***
IDP	59.6	155	--	57.6 vs 63.6	65.0 vs. 51.0*	31.7 vs. 30.0
Non-IDP	64.7	537	--	63.5 vs. 65.7	68.6 vs. 51.3***	30.6 vs. 30.1
Oral contraceptives						
Married	82.8	636	82.7 vs. 82.9	81.4 vs. 84.0	83.8 vs. 80.9	33.8 vs. 33.3
Unmarried	82.3	261	79.4 vs. 83.1	83.0 vs. 81.1	82.8 vs. 76.2	22.1 vs. 21.7
IDP	81.9	213	--	80.2 vs. 85.2	83.1 vs. 80.0	31.0 vs. 30.6
Non-IDP	82.9	688	--	82.7 vs. 83.1	83.5 vs. 80.8	29.5 vs. 30.4
Injectable						
Married	77.3	594	74.0 vs. 78.5	73.1 vs. 80.7*	76.1 vs. 79.8	33.9 vs. 33.2
Unmarried	68.8	218	69.8 vs. 68.5	68.0 vs. 70.3	69.6 vs. 57.1	22.0 vs. 22.1
IDP	72.7	189	--	70.9 vs. 76.1	75.6 vs. 68.0	30.9 vs. 30.6
Non-IDP	75.4	626	--	70.9 vs. 79.1**	73.3 vs. 82.9**	28.7 vs. 30.8**
Implant						
Married	9.0	69	1.0 vs. 11.7***	6.8 vs. 10.7	11.3 vs. 4.6**	36.5 vs. 33.5**
Unmarried	1.6	5	0 vs. 2.0	1.0 vs. 2.7	1.7 vs. 0	24.6 vs. 22.0
IDP	0.8	2	--	0.6 vs. 1.1	1.3 vs. 0.0	30.6 vs. 35.0
Non-IDP	8.7	72	--	6.4 vs. 10.6*	9.3 vs. 6.4	29.7 vs. 35.7***

* p<0.05, **p<0.01, ***p<0.001
† of men reporting awareness of FP

Table 3.42 displays stated agreement, disagreement, and lack of knowledge about four FP facts or misconceptions. When asked about popular FP misconceptions, 25 percent of the men responded that they did not know if using pills or injections would make it impossible for a woman to become pregnant after discontinued use. More than one-third of men agreed with this statement. While married men were more likely than unmarried men to have correct knowledge for all statements, these levels were still below 50 percent.

Table 3.42. Family planning perceptions and misconceptions among men, by marital and IDP status (Afghanistan, 2017) (n=1,658) (correct response in bold)

Family Planning Knowledge Statements	Frequency Distribution, % (n)			
	Agree	*Disagree*	*Do Not Know*	*No Response*
Young women should not use family planning methods because it may create problems getting pregnant later.				
Overall	38.4 (636)	**34.9 (578)**	25.5 (423)	1.3 (21)
Married	41.6 (469)	**36.3 (409)**	20.6 (232)	1.5 (17)
Unmarried	31.5 (167)	**31.8 (169)**	36.0 (191)	0.8 (4)
IDP	44.9 (202)	**36.7 (165)**	16.9 (76)	1.6 (7)
Non-IDP	35.9 (434)	**34.2 (413)**	28.7 (347)	1.2 (14)
Withdrawal is a highly effective method for preventing pregnancy.				
Overall	47.2 (782)	**25.8 (427)**	20.8 (345)	6.3 (104)
Married	46.7 (526)	**27.6 (311)**	18.2 (205)	7.5 (85)
Unmarried	48.2 (256)	**21.9 (116)**	26.4 (140)	3.6 (19)
IDP	54.4 (245)	**24.7 (111)**	17.8 (80)	3.1 (14)
Non-IDP	44.5 (537)	**26.2 (316)**	21.9 (265)	7.5 (90)
The IUCD or loop can prevent pregnancy for up to 10 years.				
Overall	**17.0 (281)**	19.1 (317)	61.8 (1025)	2.1 (35)
Married	**18.2 (205)**	21.6 (243)	57.5 (648)	2.8 (31)
Unmarried	**14.3 (76)**	13.9 (74)	71.0 (377)	0.8 (4)
IDP	**22.2 (100)**	25.3 (114)	49.8 (224)	2.7 (12)
Non-IDP	**15.0 (181)**	16.8 (203)	66.3 (801)	1.9 (23)
Irregular periods or bleeding between periods while using the injection or implant will usually resolve on its own.				
Overall	**17.6 (291)**	20.6 (341)	57.2 (949)	4.6 (77)
Married	**19.7 (222)**	22.9 (258)	52.1 (587)	5.3 (60)
Unmarried	**13.0 (69)**	15.6 (83)	68.2 (362)	3.2 (17)
IDP	**24.4 (110)**	30.0 (135)	42.0 (189)	3.6 (16)
Non-IDP	**15.0 (181)**	17.1 (206)	62.9 (760)	5.1 (61)

Variables associated with correct FP statement knowledge using logistic regression analysis are shown in Table 3.43.

Table 3.43. Associations between sociodemographic characteristics and correct knowledge of family planning among men (Afghanistan, 2017) (n=1658)

	Mean Age (Years) (Those with Correct vs. Incorrect Knowledge)	Any Formal Education (%)	Sought Care from Provider in Past 6 months (%)	Province (%)	Residence (%) (Urban vs. Rural)	IDP (%) (IDP vs. non-IDP)	Listens to Radio at Least Weekly (%)
Withdrawal is a highly effective method for preventing pregnancy.							
Married	34.4 vs. 33.3*	25.2 vs. 31.0*	25.6 vs. 28.9	Balkh: 44.4 Bamyan: 23.6 Herat: 27.3 Kabul: 14.4 Kandahar: 16.7 Nangarhar: 40.6 Takhar: 22.5	24.6 vs. 29.9*	27.3 vs. 27.7	
Unmarried	21.6 vs. 21.6	21.9 vs. 21.0	22.7 vs. 21.2	Balkh: 29.6 Bamyan: 20.2 Herat: 26.3 Kabul: 14.9 Kandahar: 7.4 Nangarhar: 42.6 Takhar: 23.1; ***	19.8 vs. 25.9	15.0 vs. 23.4	
IDP	30.6 vs. 32.0	17.9 vs. 32.4***	22.4 vs. 26.5	Kabul: 13.2 Kandahar: 13.7 Nangarhar: 46.4***	12.9 vs. 39.1***	---	
Non-IDP	28.9 vs. 30.7**	25.4 vs, 28.3	25.9 vs. 26.3	Balkh: 41.7 Bamyan: 22.5 Herat: 26.7 Kabul: 16.0 Nangarhar: 35.3 Takhar: 22.6; ***	26.6 vs. 25.7	---	
Young women should not use family planning methods because it may create problems getting pregnant later.							
Married	34.3 vs. 33.2*	36.5 vs. 36.0	39.8 vs. 34.0	Balkh: 50.0 Bamyan: 27.4 Herat: 56.4 Kabul: 32.3 Kandahar: 21.9 Nangarhar: 44.2 Takhar: 33.1***	36.9 vs. 35.9	38.5 vs. 35.3	

	Mean Age (Years) (Those with Correct vs. Incorrect Knowledge)	Any Formal Education (%)	Sought Care from Provider in Past 6 months (%)	Province (%)	Residence (%) (Urban vs. Rural)	IDP (%) (IDP vs. non-IDP)	Listens to Radio at Least Weekly (%)
Unmarried	21.8 vs. 21.5	32.8 vs. 22.6	39.3 vs. 26.3**	Balkh: 59.3 Bamyan: 25.5 Herat: 51.6 Kabul: 19.4 Kandahar: 20.4 Nangarhar: 46.3 Takhar: 21.5***	32.3 vs. 30.0	29.0 vs. 32.2	
IDP	32.5 vs. 30.1**	34.6 vs. 39.1	37.6 vs. 35.9	Kabul: 36.4 Kandahar: 21.2 Nangarhar: 51.6***	31.1 vs. 43.6**	---	
Non-IDP	30.1 vs. 29.0*	35.1 vs. 31.8	40.7 vs. 30.3***	Balkh: 51.7 Bamyan: 26.8 Herat: 53.3 Kabul: 16.7 Nangarhar: 37.3 Takhar: 30.6***	36.7 vs. 31.7	---	
The IUCD or loop can prevent pregnancy for up to 10 years.							
Married	34.2 vs. 33.4	19.7 vs. 16.1	20.9 vs. 16.5	Bamyan: 17.3 Herat: 10.9 Kabul: 21.7 Kandahar: 47.4 Nangarhar: 8.4 Takhar: 17.9***	23.2 vs. 14.3***	23.0 vs. 16.1**	18.1 vs. 18.2
Unmarried	22.1 vs. 21.5	15.0 vs. 9.7	14.2 vs. 14.4	Balkh: 25.9 Bamyan: 18.1 Herat: 7.4 Kabul: 14.2 Kandahar: 29.6 Nangarhar: 7.4 Takhar: 7.7**	15.3 vs. 12.4	19.0 vs. 13.2	13.0 vs. 15.4
IDP	31.4 yrs. vs. 30.8	22.9 vs. 21.4	22.0 vs. 22.5	Kabul: 23.2 Kandahar: 41.8 Nangarhar: 2.6***	31.1 vs. 11.4***	---	19.1 vs. 27.0*

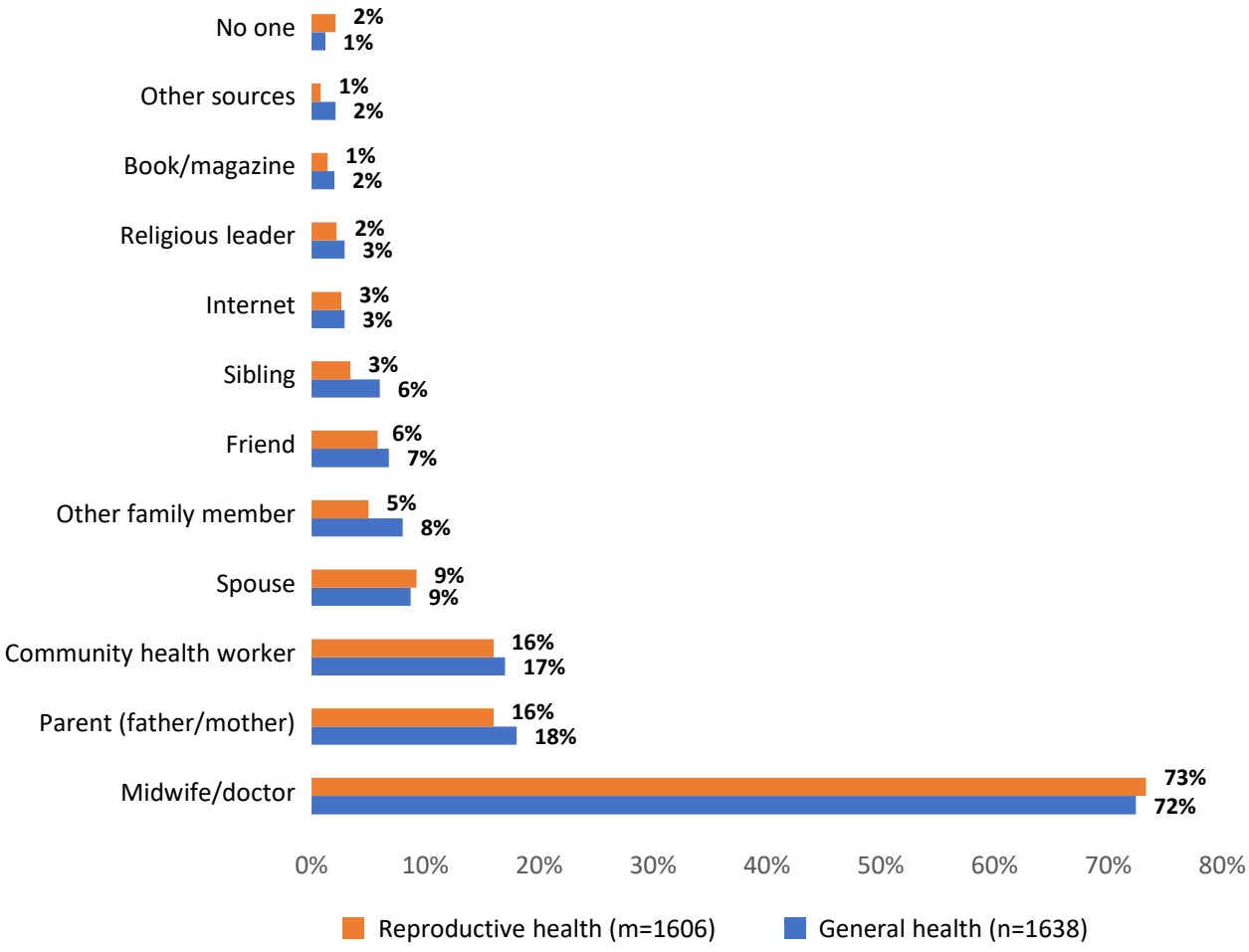
	Mean Age (Years) (Those with Correct vs. Incorrect Knowledge)	Any Formal Education (%)	Sought Care from Provider in Past 6 months (%)	Province (%)	Residence (%) (Urban vs. Rural)	IDP (%) (IDP vs. non-IDP)	Listens to Radio at Least Weekly (%)
Non-IDP	30.7 yrs. vs. 29.1*	16.3 vs. 11.3*	17.3 vs. 13.6	Balkh: 17.2 Bamiyan: 17.5 Herat: 8.7 Kabul: 14.0 Nangarhar: 14.0 Takhar: 15.6	15.3 vs. 14.7	---	14.9 vs. 15.1
Irregular periods or bleeding between periods while using the injection or implant will usually resolve on its own.							
Married	34.5 vs. 33.4	20.3 vs. 18.9	21.4 vs. 18.6	Balkh: 16.1 Bamiyan: 23.1 Herat: 12.7 Kabul: 9.0 Kandahar: 61.5 Nangarhar: 17.7 Takhar: 13.1***	23.1 vs. 17.1*	25.1 vs. 17.3**	23.7 vs. 16.8**
Unmarried	22.5 vs. 21.5*	13.4 vs. 8.1	11.4 vs. 13.8	Balkh: 18.5 Bamyan: 21.3 Herat: 7.4 Kabul: 3.0 Kandahar: 31.5 Nangarhar: 7.4 Takhar: 15.4***	12.5 vs. 13.5	22.0 vs. 10.6**	13.5 vs. 12.3
IDP	31.9 vs. 30.6	23.3 vs. 25.7	26.3 vs. 22.9	Kabul: 11.3 Kandahar: 50.7 Nangarhar: 12.4	27.0 vs. 21.3	---	
Non-IDP	31.7 vs. 29.0***	16.0 vs. 12.3	14.4 vs. 15.3	Balkh: 16.6 Bamiyan: 22.5 Herat: 9.3 Kabul: 1.3 Nangarhar: 19.3 Takhar: 13.6***	15.3 vs. 14.7	---	

Province of recruitment was associated with significant differences in knowledge levels for all statements among most segmented groups of adult men. No one province had consistently high knowledge levels for all statements. There were no other consistent associations across statements by segmented group.

Care Utilization and Sources of Health Information

One-third (35.8 percent, n=590) of men reported seeking care at a health facility, and 29.1 percent met with a CHW in the past three months. One-fourth (27.4 percent) reported having a shura e sehaie (health shura) in their communities; of these men, 35.5 percent (n=160/451) had met with a member in the past three months. Family Health Action (FHA) groups are community volunteer groups of trained married women who disseminate FP/RMNCH messages and encourage engagement with CHWs for referrals; these groups have been established in all provinces, with variable distribution. Few men reported an FHA group in their community (12.1 percent, n=199/1644); presence was more likely for Balkh (24.7 percent) and Nangarhar (20.7 percent) than for Bamyan (10 percent), Herat (5.7 percent), Kabul (8.7 percent), Kandahar (15.2 percent), or Takhar (3.3 percent). Of men reporting FHA groups in their communities, 39.9 percent reported meeting with any of the FHA members in the past three months. The most frequently consulted health information sources are presented in Figure 3.29.

Figure 3.29. Usual sources of health information among men (Afghanistan, 2017) (n=1638)



Most (92.5 percent) men agreed when asked if they would be likely to use a free mobile phone-based service for FP/RMNCH information: 64.7 percent (n=1017) said they were very likely, and a further 27.8 percent reported being somewhat likely to use such a service. Likelihood of using this service was slightly lower for men from Bamyan (88.3 percent) and Kabul (82.6 percent), and higher among younger than

older men (mean age, 29.6 years versus 31.7 years, p=0.02) and among educated participants than those with no education (93.8 percent versus 89.7 percent, p=0.004); these differences were similar when segmented by IDP and marital status. Most men (76.9 percent, n=1275) reported preferring to speak with a live person for this service, while 20.1 percent preferred a recording; 3.0 percent were unsure. We did not inquire about preferences for text rather than voice messages.

Marriage Attitudes and Household Decision Making

Attitudes regarding gender equity and norms within marital relationships were gauged. Many men disagreed with statements justifying wife beating, statements regarding the promiscuity of women who use FP, and the belief that FP is a woman's business only (Table 3.44).

Table 3.44. Level of agreement or uncertainty regarding gender equity and norms within marriage among men, by marital and IDP status (Afghanistan, 2017) (number variable; proportion disagreeing or declining to respond not shown)

Attitude Statement	Marital Status				IDP Status			
	Married % Agree	Unmarried % Agree	Married % Do Not Know	Unmarried % Do Not Know	IDP % Agree	Non-IDP % Agree	IDP % Do Not Know	Non-IDP % Do Not Know
Husband is justified to beat wife if she goes out without telling him. (n=1,640)	32.8 (n=369)	37.5 (n=193)	0.9 (n=10)	1.6 (n=8)	44.8 (n=199)	30.4 (n=363)	0 (n=0)	1.5 (n=18)
Husband is justified to beat wife if she neglects the children. (n=1,642)	19.0 (n=214)	24.3 (n=126)	0.4 (n=4)	0.6 (n=3)	29.3 (n=102)	19.9 (n=238)	0.5 (n=1)	0.5 (n=6)
Husband is justified to beat wife if she argues with him. (n=1,635)	20.9 (n=234)	26.4 (n=136)	0.5 (n=6)	1.0 (n=5)	24.7 (n=110)	21.8 (n=260)	0.9 (n=4)	0.6 (n=7)
Husband is justified to beat wife if she burns the food. (n=1,642)	9.7 (n=109)	13.4 (n=69)	0.4 (n=2)	0.7 (n=8)	12.8 (n=57)	10.1 (n=121)	0.7 (n=3)	0.6 (n=7)
Husband is justified to beat wife if she refuses to have sex with him. (n=1,593)	14.7 (n=160)	19.9 (n=100)	6.1 (n=67)	11.8 (n=59)	21.2 (n=92)	14.5 (n=168)	4.2 (n=18)	9.3 (n=108)
Contraception is a woman's business and a man should not have to worry about it. (n=1,630)	27.5 (n=306)	27.1 (n=140)	5.8 (n=65)	11.0 (n=57)	27.7 (n=124)	27.2 (n=322)	7.6 (n=34)	7.4 (n=88)
Women who use contraception may become promiscuous. (n=1,606)	36.5 (n=402)	28.1 (n=142)	27.4 (n=302)	39.8 (n=201)	40.4 (n=178)	31.4 (n=366)	19.0 (n=84)	40.0 (n=419)

We conducted further analysis to determine associations between agreement with selected conditions for IPV (i.e., going out without the husband's permission, arguing with him) and key sociodemographic variables. Men reporting any education were less likely than those reporting no education to agree with the acceptability of beating one's wife for going out without permission (29.4 percent versus 37.6 percent for married, p=0.004 and 35.8 percent versus 50.0 percent for unmarried, p=0.03). Irrespective of marital status, participants from Nangarhar (59.8 percent

for married and 51.9 percent for unmarried, p<0.001) and younger men (mean age, 32.7 years versus 34.1 years for married, p=0.01 and 20.9 years versus 22.0 years for unmarried, p=0.001) were more likely to agree with this statement. Among married men, rural location (35.5 percent for rural versus 29 percent for urban, p=0.03) was associated with higher rates of agreement. However, among unmarried men, urban men were more likely to agree than rural men (44.5 percent versus 29.3 percent, p=0.008). Among unmarried men, rates of agreement in Kabul were also higher (52.6 percent) than in most other provinces. Among both IDPs and non-IDPs, recruitment from Nangarhar was associated with higher rates of agreement than recruitment from other provinces (63.3 percent and 52.4 percent, respectively, p<0.001). Among IDPs, recruitment from an urban area was associated with higher rates of agreement than recruitment from a rural area (54.8 percent versus 36.4 percent, p<0.001); among non-IDPs, rural men were more likely to agree with this statement (33.4 percent versus 27.5 percent for urban men, p=0.03). For non-IDPs, both younger age (mean age, 27.4 years for agreeing versus 30.4 years for disagreeing, p<0.001) and recruitment in Kabul (42.2 percent, p<0.001) were associated with agreeing with this statement.

For the statement regarding acceptability of beating a wife for arguing with her husband, younger age (20.6 years versus 22.0 years, p=0.001) and recruitment from Kabul (39.1 percent) or Herat (28.4 percent, p<0.001) were significantly associated with higher agreement levels. For married men, participants recruited from Nangarhar (30.9 percent) or Balkh (25.8 percent, p=0.006) were more likely to agree than participants recruited from other provinces. For IDP men, rural residence (31.0 for rural versus 19.8 percent for urban, p=0.04) and recruitment from Nangarhar (35.8 percent, p<0.001) were associated with higher levels of agreement. By contrast, among non-IDPs, younger age (27.7 years for agreeing versus 29.9 years for not agreeing, p=0.007), urban residence (24.4 percent for urban versus 19.4 percent for rural, p=0.04), and recruitment from Kabul (34.2 percent, p=0.001) were significantly associated with higher levels of agreement.

Table 3.45 presents men's FP/RMNCH perceived norms. Although most men agreed with statements regarding women's ability to seek appropriate ANC from providers and community support for FP use/delivery at health facilities, there was less consensus around community perception of husbands' involvement in their wives' pregnancies and use of FP methods.

Table 3.45. Perceived social norms concerning maternal, newborn, and child health and family planning among men, by marital and IDP status (Afghanistan, 2017) (n=1,658)

	Marital Status						IDP Status					
	Married (n=1,135)			Unmarried (n=523)			IDP (n=450)			Non-IDP (n=1208)		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
Husbands and wives in my community use family planning to space births.	79.3% (900)	11.2% (127)	9.5% (108)	82.6% (432)	9.6% (50)	7.8% (41)	78.7% (354)	12.2% (55)	9.1% (41)	81.0% (978)	10.1% (122)	8.9% (108)
Women in my community get care for their pregnancies from health providers before delivery.	87.3% (1091)	6.7% (76)	6.0% (68)	83.8% (438)	10.3% (54)	5.9% (31)	84.4% (380)	8.2% (37)	7.3% (33)	86.8% (1049)	7.7% (93)	5.5% (66)
Women in my community give birth at health facilities.	88.2% (1001)	5.9% (67)	5.9% (67)	89.7% (469)	5.4% (28)	5.0% (26)	80.2% (361)	11.3% (51)	8.5% (38)	91.8% (1109)	3.6% (44)	4.6% (55)

	Marital Status						IDP Status					
	Married (n=1,135)			Unmarried (n=523)			IDP (n=450)			Non-IDP (n=1208)		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
Women in my community go to health facility/ talk to health workers about family planning methods.	81.1% (920)	9.8% (111)	9.1% (104)	80.5% (421)	10.9% (57)	8.6% (45)	74.4% (335)	12.0% (54)	13.6% (61)	83.3% (1006)	9.4% (114)	7.3% (88)
Men in my community go to health facility/ talk to health workers about family planning methods.	70.8% (804)	11.7% (133)	17.4% (198)	78.8% (412)	11.3% (59)	9.9% (52)	70.7% (318)	16.7% (75)	12.7% (57)	74.3% (898)	9.7% (117)	16.0% (193)
Men in my community go to health facility/ talk to health workers about antenatal care and birth planning.	71.7% (814)	11.1% (126)	17.2% (195)	77.8% (407)	11.9% (62)	9.3% (54)	71.3% (321)	15.1% (68)	13.6% (61)	74.5% (900)	9.9% (120)	15.6% (188)
People in my community are supportive regarding family planning use.	83.0% (942)	9.6% (109)	7.4% (84)	82.4% (431)	9.9% (52)	7.7% (40)	77.8% (350)	11.1% (50)	11.1% (50)	84.7% (1023)	9.2% (111)	6.1% (74)
People in my community are supportive regarding delivering in a health facility.	86.8% (985)	8.0% (91)	5.2% (59)	88.7% (464)	6.1% (32)	5.2% (27)	78.9% (355)	11.8% (53)	9.3% (42)	90.6% (1094)	5.8% (70)	3.6% (44)
Men in my community are involved family planning.	81.9% (929)	11.0% (125)	7.1% (81)	83.4% (436)	11.7% (61)	5.0% (26)	74.4% (335)	16.9% (76)	8.7% (39)	85.3% (1030)	9.1% (110)	5.6% (68)
Men in my community are involved in birth preparedness planning.	81.9% (929)	12.4% (141)	6.7% (65)	83.8% (438)	11.3% (59)	5.0% (26)	72.9% (328)	17.6% (79)	9.6% (43)	86.0% (1039)	10.0% (121)	4.0% (48)
I feel confident that my wife and I can use family planning to space between births.	82.6% (938)	10.0% (114)	7.3% (83)	78.6% (411)	15.5% (81)	5.9% (31)	68.4% (308)	19.1% (86)	12.4% (56)	86.2% (1041)	9.0% (109)	5.8% (58)
I feel knowledgeable when discussing birth spacing with my wife.	74.7% (848)	10.8% (122)	14.5% (165)	70.4% (368)	19.9% (104)	9.8% (51)	61.3% (276)	19.1% (86)	19.6% (88)	77.8% (940)	11.6% (140)	10.6% (128)
I feel knowledgeable discussing a birth plan with my wife.	72.5% (823)	13.2% (150)	14.3% (162)	69.8% (365)	19.7% (103)	10.5% (55)	60.0% (270)	22.7% (102)	17.3% (78)	76.0% (918)	12.5% (151)	11.5% (139)
I feel knowledgeable discussing health care for the children with my wife.	74.3% (843)	11.1% (126)	14.6% (166)	70.0% (366)	20.7% (108)	9.4% (49)	63.3% (285)	18.7% (84)	18.0% (81)	76.5% (924)	12.4% (150)	11.1% (134)

	Marital Status						IDP Status					
	Married (n=1,135)			Unmarried (n=523)			IDP (n=450)			Non-IDP (n=1208)		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
I feel confident asking my wife about family planning methods.	76.8% (872)	12.3% (139)	10.9% (124)	72.9% (381)	22.2% (116)	5.0% (26)	63.6% (286)	22.2% (100)	14.2% (64)	80.1% (967)	12.8% (155)	7.1% (86)
I feel confident that I can save money to support my family in case of emergency during pregnancy or delivery.	86.2% (978)	9.2% (104)	4.7% (53)	84.5% (442)	13.4% (70)	2.1% (11)	74.0% (333)	18.9% (85)	7.1% (32)	90.0% (1087)	7.4% (89)	2.7% (32)
I believe that frequent childbearing with short spacing between births is harmful to the health of the mother.	87.8% (969)	6.2% (70)	6.1% (69)	89.3% (467)	6.9% (36)	3.8% (20)	79.3% (357)	11.8% (53)	8.9% (40)	91.6% (1106)	4.4% (53)	4.1% (49)
I believe that early (before age 18) childbearing is harmful to the health of the mother.	88.2% (1001)	6.0% (68)	5.8% (66)	90.1% (471)	6.7% (35)	2.3% (17)	77.6% (349)	12.9% (58)	9.6% (43)	93.0% (1132)	3.7% (45)	3.3% (40)
I believe that using family planning methods to space children is safe.	82.1% (932)	9.4% (107)	8.5% (96)	84.1% (440)	11.5% (60)	4.4% (23)	76.4% (344)	13.6% (61)	10.0% (45)	85.1% (1028)	8.8% (106)	6.1% (74)
Most family planning methods can be removed/stopped any time you want to be pregnant.	64.3% (730)	25.2% (286)	10.5% (109)	65.6% (343)	24.9% (130)	9.6% (50)	56.9% (256)	31.3% (141)	11.8% (53)	67.6% (817)	22.8% (275)	9.6% (96)
Going to at least four ANC visits can help women have healthier babies.	89.8% (1019)	6.9% (78)	3.4% (38)	91.0% (476)	6.1% (32)	2.9% (15)	81.1% (365)	11.6% (52)	7.3% (33)	93.5% (1130)	4.8% (58)	1.7% (20)
Families are more prepared for having babies if husbands are involved in their wives' family planning use.	83.3% (945)	10.8% (123)	5.9% (67)	83.0% (434)	13.0% (68)	4.0% (21)	77.1% (347)	14.0% (63)	8.9% (40)	85.4% (1032)	10.6% (128)	4.0% (48)
If a woman experiences complications during delivery, she is more likely to get the help she needs at a health facility than if she gives birth at home.	86.0% (976)	8.2% (93)	5.8% (66)	86.0% (450)	8.8% (46)	5.2% (27)	79.3% (357)	11.1% (50)	9.6% (43)	88.5% (1096)	7.4% (89)	4.1% (50)
Families are more likely to have healthy babies and mothers if husbands are involved in their wives' birth preparedness planning.	87.8% (996)	8.9% (101)	2.4% (38)	86.6% (453)	10.3% (54)	3.1% (16)	80.9% (364)	11.8% (53)	7.3% (33)	89.8% (1085)	8.4% (102)	1.7% (21)

	Marital Status						IDP Status					
	Married (n=1,135)			Unmarried (n=523)			IDP (n=450)			Non-IDP (n=1208)		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
Families who use family planning to space their pregnancies have a better future than families who do not use family planning.	83.9% (952)	10.4% (118)	5.7% (65)	84.7% (443)	9.9% (52)	5.4% (28)	75.1% (338)	13.8% (62)	11.1% (50)	87.5% (1057)	8.9% (108)	3.6% (43)
It is difficult for women to get family planning methods.	46.1% (523)	13.0% (148)	40.9% (464)	47.8% (250)	15.1% (79)	37.1% (194)	47.8% (215)	20.0% (90)	32.2% (145)	46.2% (558)	11.3% (137)	42.5% (513)
It is difficult for women to go to at least four antenatal visits during pregnancy.	41.7% (437)	10.2% (116)	48.1% (546)	41.9% (219)	9.6% (50)	48.6% (254)	46.9% (211)	16.0% (72)	37.1% (167)	39.8% (481)	7.8% (94)	52.4% (633)
It is difficult for pregnant women to access healthy foods.	49.8% (565)	10.9% (124)	39.3% (446)	49.3% (285)	11.1% (58)	39.6% (207)	45.3% (204)	18.2% (82)	36.5% (164)	51.2% (619)	8.3% (100)	40.5% (389)
It is difficult for women to be able to give birth in health facilities.	39.9% (453)	9.1% (103)	51.0% (579)	37.7% (197)	9.0% (47)	52.3% (279)	35.6% (160)	16.9% (76)	47.6% (214)	40.6% (490)	6.1% (74)	53.3% (644)
It is difficult for infants to get care in health facilities.	43.4% (493)	14.5% (165)	42.0% (477)	44.9% (235)	10.9% (57)	44.2% (231)	38.2% (172)	22.4% (101)	39.3% (177)	46.0% (556)	10.0% (121)	44.0% (531)
My community wouldn't think it is appropriate for husbands to be involved in their wives' use of family planning methods.	45.3% (514)	20.4% (231)	34.4% (390)	46.1% (241)	20.1% (105)	33.8% (177)	44.7% (201)	25.3% (114)	30.0% (135)	45.9% (554)	18.4% (222)	35.8% (432)
My community wouldn't think it is appropriate for husbands to be involved in their wives' pregnancies.	43.4% (492)	18.7% (212)	38.0% (431)	48.4% (253)	17.6% (92)	34.0% (178)	55.6% (208)	24.4% (110)	29.3% (132)	44.5% (537)	16.1% (194)	39.5% (477)
I support the use of family planning to space our children.	83.7% (950)	8.8% (100)	7.5% (85)	86.4% (452)	7.3% (38)	5.3% (33)	73.1% (329)	15.1% (68)	11.8% (53)	88.8% (1073)	5.8% (70)	5.4% (65)
My mother supports using family planning methods for spacing.	78.5% (891)	14.3% (162)	7.2% (82)	81.5% (426)	11.9% (62)	6.7% (35)	68.4% (308)	19.3% (87)	12.2% (55)	83.5% (1008)	11.3% (137)	5.1% (62)
My mother supports the decision for my wife to deliver at a health facility.	82.6% (937)	12.2% (138)	5.3% (60)	84.9% (444)	9.9% (52)	5.2% (27)	73.3% (320)	16.4% (74)	10.2% (46)	87.0% (1051)	9.6% (116)	3.4% (41)
Men like me believe that a husband's involvement in family planning is good.	86.2% (978)	8.0% (91)	5.8% (66)	85.3% (446)	10.7% (56)	4.0% (21)	78.2% (352)	11.1% (50)	10.7% (48)	88.7% (1072)	8.0% (97)	3.2% (39)

	Marital Status						IDP Status					
	Married (n=1,135)			Unmarried (n=523)			IDP (n=450)			Non-IDP (n=1208)		
	Agree	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*	*Agree*	*Neutral*	*Disagree*
Men like me believe that spousal communication on birth spacing will help on acceptance of family planning methods.	84.6% (960)	10.0% (113)	5.5% (62)	84.9% (444)	11.3% (59)	3.8% (20)	74.9% (337)	14.4% (65)	10.7% (48)	88.3% (1067)	8.9 (107)	2.8% (34)
Men like me believe that care during pregnancy is essential.	88.6% (1006)	7.8% (89)	3.5% (40)	90.6% (474)	5.7% (30)	3.6% (19)	80.2% (361)	12.0% (54)	7.8% (35)	92.6% (1119)	5.4% (65)	2.0% (24)
Men like me believe that delivery at a health facility is safe.	87.2% (990)	7.1% (81)	5.6% (64)	89.1% (466)	7.7% (40)	3.3% (17)	77.3% (348)	14.2% (64)	8.5% (38)	91.7% (1108)	4.7% (57)	3.6% (43)

There was little consensus among participants reacting to several statements, specifically perceptions surrounding difficulty accessing various aspects of FP/MNCH care as well as community beliefs around husbands' involvement in FP/MNCH care, as participants expressed agreement, neutrality, and disagreement in roughly equivalent proportions across each segmented group. We further probed this relationship with an analysis of factors associated with agreement with these particular statements (Table 3.46). Generally, there were significant differences between provinces of recruitment for the same segmented groups, but these differences were not always consistent between provinces. Formal education and reported television and Internet use significantly reduced agreement with perceived women's difficulty accessing FP/MNCH care and community disapproval of male involvement in FP and pregnancy care, as did reported collaborative spousal decision making among married men for at least one type of household decision.

Table 3.46. Correlates of agreement with perceptions surrounding FP/MNCH care access and community social norms that lacked consensus among segmented populations of adult men (Afghanistan, 2017) (n=1,658)

	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)
Statement	*Agree that it is difficult for women to get family planning methods.*				*Agree that it is difficult for women to go to at least four antenatal visits during pregnancy.*			
Variable								
Age (mean+SD)	33.55+8.8 vs. 33.63+8.5	21.58+4.0 vs. 21.63+3.1	31.0+9.54 vs. 30.88+9.19	29.15+9.38 vs. 29.58+9.07	33.26+8.7 vs. 33.83+8.6	21.57+4.1 vs. 21.63+3.2	30.4+9.1 vs. 31.4+9.5	29.2+9.3 vs. 29.5+9.2
Monthly household income (mean+SD)	9,333+10,879 vs. 9,855+7,870	13,066+10,608 vs. 15,163+ 22,281	8,740+8,612 vs. 11,297+ 10,088**	11,199+11,638 vs. 11,611+ 15,461	9,084+10,761 vs. 9,977+8,257	11,999+9,606 vs. 15,615+21,588*	9,325+9,641 vs. 10,708+ 9,320	10,273+ 10.853 vs. 12,112+ 15,399*

	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)
Province: Herat (n=150) Bamyan (n=302) Takhar (n=301) Kabul (n=301) Kandahar (n=150) Nangarhar (n=303) Balkh (n=151)	*** 23.6% 65.4% 25.0% 57.5% 37.5% 43.0% 61.3%	*** 27.4% 61.7% 21.5% 70.9% 42.6% 38.9% 48.1%	*** -- -- -- 59.6% 38.4% 45.1% --	*** 26.0% 64.2% 24.3% 67.3% -- 39.3% 58.9%	*** 18.2% 60.6% 21.6% 48.5% 34.4% 42.6% 53.2%	*** 16.8% 62.8% 15.4% 56.7% 42.6% 42.6% 44.4%	* -- -- -- 53.0% 37.0% 50.3% --	*** 17.3% 61.3% 20.3% 51.3% -- 34.7% 51.7%
Any formal education vs. no formal education	42.6% vs. 51.1%**	46.4% vs. 58.1%	43.3% vs. 52.9%*	44.4% vs. 51.3%*	39.3% vs. 45.1%*	40.8% vs. 50.0%	46.3% vs. 47.6%	38.2% vs. 44.3%
Current urban residence vs. current rural residence	51.7% vs. 41.7%***	51.3% vs. 40.6%*	50.8% vs. 44.1%	51.8% vs. 40.6%***	44.7% vs. 39.3%	41.6% vs. 42.4%	46.0% vs. 48.0%	42.4% vs. 37.3%
IDP vs. non-IDP	48.9% vs. 44.8%	44.0% vs. 48.7%	N/A	N/A	47.7% vs. 38.9%**	44.0% vs. 41.4%	N/A	N/A
Ever use Internet vs. no prior Internet use	42.5% vs. 47.1%	41.1% vs. 53.1%**	38.1% vs. 50.4%*	42.7% vs. 47.7%	33.1% vs. 44.2%***	32.6% vs. 49.3%***	33.0% vs. 50.7%**	32.8% vs. 43.1%***
Watch television at least weekly vs. watch less than weekly or not at all	41.2% vs. 51.6%***	43.8% vs. 53.4%*	41.1% vs. 52.0%*	42.3% vs. 52.2%***	35.0% vs. 49.2%***	38.2% vs. 47.0%*	40.6% vs. 50.9%*	35.0% vs. 47.2%***
Listen to radio at least weekly	47.7% vs. 44.8%	50.0% vs. 46.1%	49.3% vs. 45.5%	48.0% vs. 45.2%	42.0% vs. 41.4%	40.9% vs. 42.7%	47.4% vs. 46.1%	38.1% vs. 40.8%
Reported joint spousal decision making for use of income	41.7% vs. 52.4%***	N/A	42.1% vs. 53.0%*†	41.7% vs. 51.9%**‡	38.2% vs. 46.7%**	N/A	38.3% vs. 53.5%**†	38.2% vs. 40.7%‡

	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)
Reported joint spousal decision making for major household purchases	43.6% vs. 50.2%***	N/A	46.8% vs. 50.5%†	42.7% vs. 50.0%*‡	39.1% vs. 46.0%*	N/A	41.6% vs. 52.6%*†	38.4% vs. 40.2%‡
Reported joint spousal decision making for health care	43.0% vs. 52.1%**	N/A	42.7% vs. 54.7%*†	43.0% vs. 49.8%‡	39.2% vs. 46.4%*	N/A	42.1% vs. 53.1%*†	38.3% vs. 40.5%‡
Statement	*It is difficult for pregnant women to access healthy foods.*				*It is difficult for women to be able to give birth in health facilities.*			
Age (mean+SD)	33.92+8.6 vs. 33.26+8.6	21.63+4.1 vs. 21.58+3.0	30.4+9.1 vs. 31.4+9.5	29.9+9.5 vs. 28.8+8.8*	33.29+8.6 vs. 33.79+8.6	21.79+4.5 vs. 21.50+2.9	30.51+8.8 vs. 31.18+9.7	29.57+9.4 vs. 29.25+9.1
Monthly household income (mean+SD)	8675+8456 vs. 10525+10042**	11169+8516 vs. 16912+23075***	9192+9719 vs. 19798+9241	9520+8135 vs. 13284+17620***	8735+9688 vs. 10165+9088*	12142+9050 vs. 15280+21105	8791+9285 vs. 10744+9534	10029+9724 vs. 12270+15847*
Province:	***	***	*	***	***	***	***	***
Herat (n=150)	21.8%	18.9%	--	20.0%	10.9%	16.8%	--	14.7%
Bamyan (n=302)	65.4%	64.9%	--	65.2%	55.8%	54.3%	--	55.3%
Takhar (n=301)	50.0%	43.1%	--	48.5%	30.1%	20.0%	--	27.9%
Kabul (n=301)	47.3%	60.4%	51.7%	54.7%	44.9%	56.7%	49.0%	51.3%
Kandahar (n=150)	33.3%	48.1%	37.0%	--	18.8%	16.7%	18.5%	--
Nangarhar (n=303)	43.0%	38.9%	47.1%	37.3%	39.8%	27.8%	38.6%	36.7%
Balkh (n=151)	65.3%	85.2%	--	68.9%	54.8%	63.0%	--	56.3%
Any formal education vs. no formal education	46.6% vs. 54.3%*	48.2% vs. 58.1%	42.9% vs. 48.1%	48.4% vs. 59.1%***	36.5% vs. 44.8%**	37.1% vs. 41.9%	32.1% vs. 39.5%	38.0% vs. 47.8%**
Current urban residence vs. current rural residence	48.1% vs. 51.1%	46.7% vs. 54.7%	47.2% vs. 43.1%	47.7% vs. 54.8%*	40.4% vs. 39.5%	39.4% vs. 34.1%	37.5% vs. 33.2%	41.0% vs. 40.1%

	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)
IDP vs. non-IDP	45.1% vs. 51.8%*	46.0% vs. 50.1%	N/A	N/A	37.4% vs. 41.0%	29.0% vs. 39.7%*	N/A	N/A
Ever use Internet vs. no prior Internet use	41.0% vs. 52.3%***	42.4% vs. 54.9%**	33.0% vs. 48.7%**	43.7% vs. 54.8%***	28.9% vs. 43.0%***	30.0% vs. 43.7%***	17.5% vs. 40.5%***	32.3% vs. 44.4%***
Watch television at least weekly vs. watch less than weekly or not at all	46.0% vs. 54.0%**	48.4% vs. 50.7%	39.4% vs. 49.1%*	48.6% vs. 55.3%*	34.1% vs. 46.5%***	34.9% vs. 41.6%	28.0% vs. 40.4%**	35.8% vs. 47.8%***
Listen to radio at least weekly	48.6% vs. 50.7%	49.1% vs. 49.5%	48.2% vs. 41.0%	49.1% vs. 52.5%	37.9% vs. 41.4%	33.9% vs. 40.6%	34.9% vs. 36.5%	37.6% vs. 42.3%
Reported joint spousal decision making for use of income	48.5% vs. 51.5%	N/A	39.0% vs. 50.0%*†	52.8% vs. 49.1%‡	36.9% vs. 44.3%*	N/A	29.3% vs. 42.4%*†	38.7% vs. 46.1%*‡
Reported joint spousal decision making for major household purchases	49.9% vs. 49.5%	N/A	33.1% vs. 52.5%***†	52.3% vs. 50.6%‡	38.4% vs. 42.4%	N/A	31.8% vs. 41.8%†	40.2% vs. 42.9%‡
Reported joint spousal decision making for health care	49.6% vs. 50.0%	N/A	39.2% vs. 50.8%*†	52.7% vs. 49.3%‡	37.8% vs. 44.0%*	N/A	33.9% vs. 40.8%†	38.9% vs. 46.8%*‡
Statement	*It is difficult for infants to get care in health facilities.*				*My community wouldn't think it is appropriate for husbands to be involved in their wives' use of family planning methods.*			
Age (mean+SD)	33.40+8.5 vs. 33.73+8.7	21.40+3.8 vs. 21.78+3.4	30.80+9.2 vs. 31.0+9.4	29.12+9.2 vs. 29.60+9.2	33.00+8.7 vs. 34.08+8.6*	21.47+4.2 vs. 21.72+2.9	30.74+9.3 vs. 31.10+9.4	28.80+9.2 vs. 29.88+9.2*
Monthly household income (mean+SD)	8860+9900 vs. 10163+8892*	12415+10099 vs. 15509+21912	8888+9141 vs. 10753+9627	10310+10346 vs. 12288+16072*	9587+10775 vs. 9646+8086	13912+13000 vs. 14441+20867	9208+8923 vs. 10698+9843	11504+12433 vs. 11375+14936

	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)
Province: Herat (n=150) Bamyan (n=302) Takhar (n=301) Kabul (n=301) Kandahar (n=150) Nangarhar (n=303) Balkh (n=151)	*** 10.9% 57.7% 39.0% 46.1% 19.8% 43.4& 57.3%	*** 21.1% 67.0% 29.2% 63.4% 16.7% 40.7% 63.0%	*** -- -- -- 50.3% 19.2% 44.4% --	*** 17.3% 60.6% 36.9% 57.3% -- 41.3% 58.3%	*** 41.8% 44.2% 32.6% 60.5% 27.1% 49.4% 58.1%	*** 37.9% 56.4% 18.5% 67.2% 24.1% 44.4% 48.1%	*** -- -- -- 57.0% 26.7% 49.7% --	*** 39.3% 48.0% 29.6% 70.0% -- 47.3% 56.3%
Any formal education vs. no formal education	40.1% vs. 48.3%**	44.5% vs. 48.4%	33.8% vs. 43.3%*	44.0% vs. 51.6%*	42.3% vs. 49.6%*	44.9% vs. 54.8%	40.0% vs. 50.0%*	44.3% vs. 50.3%
Current urban residence vs. current rural residence	42.1% vs. 44.5%	45.3% vs. 44.1%	38.7% vs. 37.6%	45.3% vs. 46.7%	49.7% vs. 41.8%**	50.1% vs. 37.6%**	45.6% vs. 43.6%	51.7% vs. 40.1%***
IDP vs. non-IDP	39.7% vs. 45.0%	33.0% vs. 47.8%**	N/A	N/A	45.7% vs. 45.0%	41.0% vs. 47.3%	N/A	N/A
Ever use Internet vs. no prior Internet use	36.1% vs. 45.4%**	38.6% vs. 50.0%**	18.6% vs. 43.6%***	41.7% vs. 47.9%*	40.2% vs. 46.6%	38.6% vs. 52.1%**	32.0% vs. 48.2%**	41.2% vs. 47.9%*
Watch television at least weekly vs. watch less than weekly or not at all	38.6% vs. 49.0%***	43.8% vs. 46.6%	30.9% vs. 42.9%**	42.5% vs. 51.4%**	38.5% vs. 52.9%***	43.8% vs. 49.3%	38.9% vs. 48.4%*	40.6% vs. 53.9%***
Listen to radio at least weekly	41.4% vs. 45.0%	41.3% vs. 47.8%	35.3% vs. 42.7%	45.0% vs. 46.6%	45.3% vs. 45.3%	43.9% vs. 47.8%	44.5% vs. 44.9%	45.0% vs. 46.3%
Reported joint spousal decision making for use of income	41.7% vs. 45.9%	N/A	33.8% vs. 43.3%†	43.7% vs. 48.1%‡	42.3% vs. 49.6%*	N/A	43.6% vs. 47.0%†	42.0% vs. 51.9%**‡

	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)
Reported joint spousal decision making for major household purchases	44.0% vs. 42.4%	N/A	39.6% vs. 39.8%†	45.2% vs. 44.6%‡	43.9% vs. 47.6%	N/A	48.1% vs. 43.9%†	42.7% vs. 50.9%*‡
Reported joint spousal decision making for health care	43.5% vs. 43.2%	N/A	39.8% vs. 39.7%†	44.6% vs. 46.3%‡	44.3% vs. 47.1%	N/A	49.1% vs. 42.5%†	42.9% vs. 51.2%*‡
Statement	*My community wouldn't think it is appropriate for husbands to be involved in their wives pregnancies.*							
Age (mean+SD)	32.54+8.5 vs. 34.40+8.7	21.47+4.1 vs. 21.73+3.0	29.53+8.6 vs. 32.15+9.8**	28.48+9.1 vs. 30.10+9.2**				
Monthly household income (mean+SD)	9903+11412 vs. 9422+7557	13674+12330 vs. 14653+21470	10138+10313 vs. 10015+8805	11522+12359 vs. 11365+14927				
Province: Herat (n=150) Bamyan (n=302) Takhar (n=301) Kabul (n=301) Kandahar (n=150) Nangarhar (n=303) Balkh (n=151)	*** 45.5% 42.3% 29.7% 60.5% 30.2% 45.4% 53.2%	*** 38.9% 53.2% 15.4% 70.9% 29.6% 57.4% 51.9%	*** -- -- -- 57.6% 30.8% 49.7% --	*** 41.3% 45.7% 26.6% 72.7% -- 45.3% 53.0%				
Any formal education vs. no formal education	41.7% vs. 45.7%	47.9% vs. 51.6%	46.3% vs. 46.2%	43.7% vs. 46.5%				
Current urban residence vs. current rural residence	45.9% vs. 41.4%	51.3% vs. 42.4%	46.8% vs. 45.5%	48.7% vs. 40.3%**				

	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)	Married (n=1135)	Unmarried (n=523)	IDP (n=450)	Non-IDP (n=1209)
IDP vs. non-IDP	45.4% vs. 42.4%	49.0% vs. 48.2%	N/A	N/A				
Ever use Internet vs. no prior Internet use	38.7% vs. 44.5%	39.8% vs. 55.2%***	39.2% vs. 48.2%	39.3% vs. 46.7%*				
Watch television at least weekly vs. watch less than weekly or not at all	37.9% vs. 49.5%***	45.4% vs. 52.5%	44.6% vs. 47.3%	39.4% vs. 52.2%***				
Listen to radio at least weekly	44.9% vs. 42.2%	46.1% vs. 50.2%	47.8% vs. 43.8%	43.7% vs. 44.9%				
Reported joint spousal decision making for use of income	40.6% vs. 47.4%*	N/A	40.6% vs. 48.4%†	40.6% vs. 46.5%‡				
Reported joint spousal decision making for major household purchases	43.0% vs. 43.8%	N/A	50.0% vs. 41.8%†	41.1% vs. 45.5%‡				
Reported joint spousal decision making for health care	42.7% vs. 44.5%	N/A	46.8% vs. 44.1%†	41.5% vs. 44.9%‡				

*p<0.05; **p<0.01; ***p<0.001; † married IDPs (n=350); ‡ married non-IDPs (n=786)

Married men were queried about household decision-making dynamics (n=1,128). Table 3.47 displays decision-making authority within households for different issues.

Table 3.47. Reported household decision-making authority among married men (Afghanistan, 2017) (n=1,128)

Issue for Decision	Husband Alone % (n)	Wife Alone % (n)	Husband and Wife Together % (n)	Other Family Member/ Other % (n)
How income is spent	31.0 (350)	1.2 (14)	60.2 (679)	7.6 (85)
Making major household purchases	25.8 (291)	2.4 (27)	63.6 (717)	8.2 (93)
Health care for family	22.3 (251)	2.8 (32)	66.8 (753)	8.2 (92)

Factors associated with joint spousal decision making for each issue are displayed in Table 3.48. Significant associations were detected between joint household decision making and IDP status, age, income, education, residence, and province; however, having seen a health provider in the past six months was not significantly associated with joint household decision making in bivariate analyses.

Table 3.48. Factors significantly associated with reported joint household decision making among married men (Afghanistan, 2017) (n=1,127)

Issue for Decision	IDP Status (%)	Mean Age, Years	Mean Monthly Income, Afs	Education (%)	Residence (%)	Province (%)
How income is spent	38.2 for IDPs vs. 70.0% for non-IDPs***	34.6 for joint decision makers vs. 32.0 for non-joint decision makers***	8,532 for joint decision makers vs. 11,166 for non-joint decision makers***	64.1 for educated vs. 54.4 for uneducated ***	52.5 for urban vs. 66.0 for rural***	Balkh: 87.1, Bamyan: 74.9 Herat: 38.2, Kabul: 57.2 Kandahar: 17.9, Nangarhar: 34.6 Takhar: 84.7***
Making major household purchases	44.3 vs. 72.1***	34.6 vs. 31.8***	8,335 vs. 11,695***	65.3 vs. 61.0	55.8 for urban vs. 69.5 for rural***	Balkh: 83.1, Bamyan: 77.3 Herat: 21.8, Kabul: 57.2 Kandahar: 43.2, Nangarhar: 39.8 Takhar: 88.9***
Health care for family	49.1 vs. 75.6***	34.5 vs. 31.7 ***	8,504 vs. 11,699 ***	69.1 vs. 63.3*	58.2 vs. 73.3%***	Balkh: 86.3, Bamyan: 82.3 Herat: 34.5, Kabul: 54.2 Kandahar: 38.9, Nangarhar: 51.0 Takhar: 87.2***

*p<0.05;***p<0.001

Of married participants, 88.9 percent (n=1,003/1,128) had living children, with a mean of 4.3 children (SD+2.8, range: 0–16). When asked whether they desired more children, 32 percent (n=361/1,116) reported they did not, while 65 percent said they did and 2.7 percent weren't sure. Of those desiring more children, 15 percent (n=109/713) stated they were unsure how many more children they would like. For those who did name a specific number, the median was 3 (IQR: 2–4). Of those desiring more children, 77 percent (n=556/725) identified the desired timing, with 48 percent (n=267/556) desiring a birth in the next 12 months and 32 percent (178) desiring another birth within the next one and two years; 25 percent were unsure.

When asked if they were currently using a FP method, 101 married men declined to respond. Of those who responded (n=1,027), 41.9 percent reported currently using a method to prevent pregnancy, 4.3 percent reported their wives were currently pregnant, and 54 percent reported not using FP at the time. Of men who stated they wanted more children, 34.0 percent said they were using a FP method. Of men stating they did not want more children, only 47.7 percent reported current FP use, with 40.7 percent not using any FP method. Among men reporting current FP use, method choice and variables associated with each method used by at least 5 percent of respondents are displayed in Table 3.49.

Table 3.49. Contraceptive method mix and factors associated with specific method use among couples, reported by married men reporting current family planning use (Afghanistan, 2017) (n=430)

Method	Overall	Mean Age, Years	IDP vs. non-IDP (%)	Urban vs. Rural (%)	Mean Monthly Income, Afs	Province (%)	Any Formal Education (%)
Oral contraceptive pills	39.8 (171)	33.6 vs. 34.6	44.4 vs. 38.5	42.6 vs. 37.9	8,926 vs. 1,1861*	Balkh: 17.4 Bamyan: 47.6 Hirat: 42.5 Kabul: 43.1 Kandahar: 60.0 Nangarhar: 14.9 Takhar: 34.3***	38.6 vs. 42.4
Injectable contraception	36.5 (157)	34.5 vs. 34.1	22.9 vs. 19.8	39.6 vs. 34.5	10,408 vs. 10,804	Balkh: 47.8 Bamyan: 44.0 Hirat: 30.0 Kabul: 45.0 Kandahar: 43.3 Nangarhar: 10.6 Takhar: 57.1***	31.2 vs. 48.5***
Male condoms	35.6 (153)	32.6 vs. 35.2***	22.2 vs. 20.2	39.6 vs. 33.0	11,320 vs. 10,288	Balkh: 30.4 Bamyan: 39.3 Hirat: 32.5 Kabul: 35.3 Kandahar: 43.3 Nangarhar: 61.7 Takhar: 2.9***	39.3 vs. 27.3*
Withdrawal	12.1 (52)	34.6 vs. 34.2	12.2 vs. 12.1	8.9 vs. 14.2	12,505 vs. 10.406	Balkh: 13.0 Bamyan: 3.6 Hirat: 7.5 Kabul: 5.9 Kandahar: 0 Nangarhar: 51.1 Takhar: 20.0***	12.8 vs. 10.6

*p<0.05; **p<0.01; p<0.001.

To contextualize behaviors surrounding pregnancy and childbirth, men with children were asked if their wives had given birth in the past two years. Of 1,128 queried, 25 declined to answer and 52.8 percent (n=582/1103) reported childbirth in the past two years. Of these, 90.3 percent stated that their wife had seen a health care provider during her pregnancy, and 10 did not know. The mean number of times a provider was seen was 3.8 (SD+2.5), as stated by the 481 men recalling a number; 84 men did not know, four stated a provider was seen 0 times, and four declined to respond. Of 546 men stating that their wives received ANC during the most recent pregnancy, only 42.1 percent reported that the provider had spoken

to them at all during any ANC visit. Of 582 respondents, 50.5 percent (n=294) stated that their wife had taken iron supplements during pregnancy, while 43.8 percent denied this and 5.7 percent did not know. Of men whose wives had delivered in the past two years (n=567), most reported delivery at a health facility—a public clinic (26.8 percent), public hospital (43.2 percent), or private clinic (6.2 percent)—while 23.8 percent reported delivery at home. Among men agreeing that facility-based delivery is optimal, 79.9 percent had wives who delivered in a facility. Of men whose wives delivered at home in the past two years, 76.3 percent agreed that delivering in a facility was optimal, reflecting that beliefs about optimal delivery site were not necessarily reflected by actions.

Half of the births were attended by a midwife (51.9 percent, n=294/567), while a doctor was present for 20.3 percent (n=115) and a nurse for 2.3 percent (n=13). One-fifth (22.4 percent) were attended by a relative or friend; for home births, most (82.2 percent, n=111/135) were attended by a relative, while a skilled provider (mainly a midwife), was available for 13.4 percent. Following delivery, only 48.2 percent (n=277/574) received postnatal care (PNC), with a mean of 2.76 visits. When asked about neonatal outcomes for the most recent delivery, 2.6 percent resulted in stillbirth or early neonatal death; of 549 surviving infants, 92 percent (n=505) were breastfed.

4. QUALITATIVE RESULTS

Results from the qualitative portion of this study were based on 49 IDIs and 11 FGDs. Results are presented in aggregate for men, male youth, and female youth. Separate groups are mentioned only when they differed substantially. This section presents the following topics:

- Perceived important health issues in the community.
- Accessing information about health.
- Communication channels for health messaging and feasibility of mobile phones for RH messaging.

Important Health Issues in the Community

Participants were asked about important health issues, both generally and specifically for adults, women, and children, within their communities. In each category, we then grouped the reported health issues according to how frequently they were reported, to reflect how their prevalence in the community.

Adult Health Issues

Infectious diseases (e.g., hepatitis, malaria) and noncommunicable diseases (e.g., diabetes) were the most commonly mentioned health issues adults face. Hepatitis was named one of the most common issues for both adults and children requiring treatment outside of Afghanistan (e.g., in Pakistan or India). As one participant reported:

> *Hepatitis is such a dangerous illness that there is no laboratory in Nangarhar for it, so we had to go to Pakistan.* (Adult Male IDP, Nangarhar, FGD 8)

Notably, RMNCH and FP topics were not spontaneously raised by participants as important adult health issues.

Women's Health Issues

When participants were asked to specifically name women's health issues, pregnancy and childbirth complications and RH concerns (e.g., menstrual disorders, FP, infertility) were prominent, suggesting either that these conditions are not as common as general adult health issues or that FP/RMNCH conditions are perceived to be solely a woman's concern. Participants also listed social issues that they saw as directly contributing to poor health, such as underage marriage and not attending ANC or PNC. Malnutrition and anemia were occasionally mentioned.

A frequently reported issue for women was complications during childbirth. A few participants stated that excessive bleeding during delivery was a serious issue resulting in maternal death:

In our area (village), women have so much bleeding during the time of birth delivery, even in some cases, the child was born alive but the mother has lost her life. (Adult Male ANA, Kabul, FGD 11)

Difficulties faced during home births were also a common concern, with participants reporting issues regarding birth attendants with little training or experience dealing with difficult births:

We must accept that there are unprofessional midwives in our community which can harm women's body due to wrong medication. It has increased women's issues. Any woman who has gone to them or had their child delivered by them, they have got health issues in the future. These issues are such as chronic backache, vaginal issue, and I even know about one case in which the midwife was not able to do the child delivery properly. The child's head had not come out of the vagina and because of lack of expertise, the child and mother were dead. This is how women pass their life in these districts. The story was from three months ago. (Male Community Leaders, Herat, FGD 9)

In the above quote, the respondent suggested that unskilled or under-skilled providers were involved in MNCH care that is accessible at the community level, but he seemed to accept this as a norm. We did not ask whether or how the situation could be improved or whether the "midwives" referred to in this quote reflected formally trained providers or whether the term was applied to both trained and untrained women who conduct deliveries. Several comments indicated that complications during delivery resulted from women trying to deliver at home and not being able to access skilled care in time, or from delays in reaching a facility. We did not probe about specific motivators for delivering at home, but spontaneous comments attributed the decision to mothers-in-law following the social norm, or to a family's lack of money to organize transportation to a facility.

Problems encountered during pregnancy included high blood pressure, bleeding, and inadequate nutrition. Some participants also raised the importance of attending ANC visits at health centers to avoid maternal complications:

Women face big health issues during their pregnancy. They need to be taken care of by doctors and midwives and they need to be provided with specific medicines and vaccines. However, a lot of women in rural areas lack these things and they could be encountered with death in some cases. (Male School-based Youth, Balkh, IDI 20)

Participants identified multiple challenges to accessing ANC, including: 1) families not having information on the importance of ANC visits; 2) economic barriers, as families don't have enough money to pay for ANC visits or transportation to health centers; 3) no nearby health care center for some participants living in rural areas; and 4) families not allowing pregnant women to see a doctor:

Interviewer: W*hy don't they (women in your community) have access to hospital, what is the reason?*
Participant: *Because this is rural area and not a city, the automobiles are not available here and they have to walk and there are many other problems. And one thing else, the husbands don't allow the pregnant women to go to hospital for checkup and says it is not good that the unknown people check you up.* (Female School-based Youth, Nangarhar, IDI 51)

Early marriage (defined as marriage under 18 years of age) and subsequent early pregnancy was reported as a serious women's health issue by both male and female youth. We did not interview enough participants to segment the responses by education, age, or marital status; we selected qualitative participants solely by IDP status and sex. Specifically, participants talked about the potential negative consequences of pregnancy among adolescents and challenges faced by young pregnant women in accessing ANC:

When they are married at a young age, they become pregnant quickly and they deliver a baby to the world which causes her child to be definitely weak and the mother herself might face many problems

due to her young age. There is a culture that they can't take the daughter-in-law to the doctor, because it is something shameful. It is not good in our culture to take the daughter-in-law to the doctor. Especially if there is a male doctor, there is no chance to take her. (Female IDP Youth, Kandahar, IDI 52)

These comments were common among female and male youth from Kandahar and Nangarhar. In this context, women reportedly cannot access care due to adherence to social norms that prohibit women's conditions to be advertised outside the household. These norms are strongly reinforced by elder female (e.g., mother-in-law) and male (e.g., head of household, husband) family members and by women themselves, especially if there is no female health provider available.

Problems with menstruation were commonly mentioned, especially by young women who were embarrassed to discuss menstrual problems with others, including their mothers and health care providers (especially male providers). However, one participant mentioned she could discuss this issue with close friends.

While most women's health issues centered on RH, a few general health concerns and conditions resulting from tasks normative to women were also mentioned, such as the harmful effects of smoke from cooking stoves:

While they bake bread or are preparing food, there are some other issues, too. She breathes the smoke while she is cooking. That smoke causes them to find lung diseases or TB disease. And breathing of smoke increases other diseases, too, because it contains carbon monoxide and carbon dioxide. They cause reaction with other elements, the result of them will be a poison compound. This poison compound slowly and slowly causes the core of breast cancer, heart cancer, and uterine cancer for women. (Male Community Leader, Bamyan, IDI 10)

Children's Health Issues

Participants reported a variety of children's health issues, with vaccine-preventable diseases (e.g., measles) and need for vaccination; common childhood illnesses of diarrhea, pneumonia, nausea, and vomiting; and malnutrition being prominent. Hepatitis and jaundice were also stated frequently, and umbilical cord infection (i.e., omphalitis) was mentioned specifically for infants.

Participants shared that not vaccinating children on time was the greatest issue, potentially reflective of extensive mass media and community-based vaccination campaigns and drives. Some men reported that mullahs say that vaccines are haram (i.e., forbidden by Islam), which is why children are not vaccinated. With regard to diarrhea, which was another stated priority child health issue, some participants said that their children get diarrhea because they play in dirty and dusty places and drink unsafe water.

Pneumonia and the common cold or cough were also frequently mentioned as child health issues. In an adult male FGD in Nangarhar, the use of opium for treating children, traditionally for cough, was mentioned. Participants said that they would give their children opium when they were sick and it has been done so widely that it has become a habit for various ailments beyond respiratory symptoms.

Adolescents and young adults also contributed youth-specific health issues. Health issues for female youth largely centered on RH and menstrual issues, though depression and other mental health and general health issues were mentioned. Issues that specifically affect male youth included motorcycle accidents, cigarette smoking, injuries from fighting, injuries from falling stones while working in the mountainous regions, and use of and addiction to opiates, hashish, and other drugs. Regarding substance misuse, some participants perceived additional barriers to seeking care:

The young boys use drugs. If they are regretful and decide not to use it, so he needs to consult with someone to treat himself, but he can't share it with someone due to embarrassment. (Female IDP Youth, Kandahar, IDI 52)

Barriers and Facilitators to Accessing Health Information

Sources of Health Information

Both youth and adult male participants reported that the most common health information sources were trained health care providers (e.g. doctors) and facilities where they work, television, radio, the Internet (e.g., through Google searches), social media platforms (e.g., Twitter, Facebook), and mullahs. Interpersonal communication with doctors or staff at health centers or hospitals was the top preference for receiving information, as they are the health information experts. We did not probe about how often participants actually used the different sources.

Television was the second most reported source. Participants discussed how they received information through television on topics such as how to care for pregnant women, FP, childbirth, child health, child care, vaccination, and hygiene and cleanliness. Participants watched television programs with health content on channels including Tolo (in particular, Abu Ali Sina, Bamdad-e-Khosh, and Dabistan-e-Bo-Ali programs), Aryana, and Maaref TV. Television channels (not health-related) that participants frequently watched were Shamshad, Hewad, Zee Cinema, B4U, Channel Yak, Arezo, Rah Farda, Tamadon, Negah, Aveena and AMC (music channel). A participant shared the importance of delivering health information through television, especially in rural areas:

For example, Maaref TV talked about the health of mothers, how to prevent pregnancy. In faraway districts, there is no midwife and hospitals and that is why children and mothers would die. The TV and media can be a communicative bridge between (urban) people and (rural) people by watching TV can solve their problems. (Female School-based Youth, Kabul, FGD 3)

The radio was another popular source. Participants reported that they had heard messages on topics like how to care for pregnant women, maternal nutrition, child health, importance of vaccinating children, and the risks of early marriage for women's health. Participants reported that they listened to the following radio stations: Shamshad, Enekas, Mili, Waranga, BBC, Bamyan Radio, KILID, and Paiwand Radio. For television and radio, we did not probe about the specific format through which the messages were conveyed, such as commercials, edutainment, or public service announcements.

Vaccinators were also mentioned frequently as a source of health information. Vaccinators are volunteers who may not have formal medical training and travel with a mobile team from village to village to vaccinate children under 5 years of age and give information about vaccination, generally during immunization campaigns. A few participants also talked about imams, mullahs, and other clergy giving information about vaccination (particularly for preventing polio). Mullahs were one of the most common sources reported, particularly by men. However, participants were divided on whether mullahs should be providing health information, as they reportedly imposed restrictions on access to care. Mullahs can be powerful in the community, providing guidance to those who are sick on the power of prayer and having strong religious faith:

The Ulema talk about Allah and his messenger and they say if you get sick, then don't go to the doctor and just submit yourself to Allah...They say to pray two Rakat and Allah will cure you. It is Allah that cures me and we believe that Allah cures the dying person by just two Rakat prayer. But the messengers of Allah and their friends had faced the same sicknesses and we also will get sick but you have to try your best and if you are not cured, then you have to go to the doctor… The words of the mullah are for our benefit because he talks from Quran and Hadith… Allah is the doer of everything but the problem

is that our faith is weak. If our faith is strong, then Allah will cure the patient when neither a doctor nor Ashraf Ghani (current President of Afghanistan) can do anything. (Adult Male IDP, Nangarhar, IDI 23)

However, participants were divided on whether mullahs should provide health information, as some participants, especially women, said that mullahs restrict them:

They (referring to religious leaders) *have imposed unrelated restrictions among people… Some of the religious leaders will force women not to go to hospital, even not allowing them to sit in front of male doctors. They will have such restriction to women.* (Male Community Leader, Bamyan, IDI 10)

Most Trusted Sources of Health Information

Most participants reported that doctors were the most trusted source of health information, as they have been educated about medical issues and can treat those who are sick or have health problems. For ANC and PNC topics, participants mentioned that doctors and, to some extent, midwives were the most trusted sources. Pediatricians were the most trusted source for health information for younger children, and general practitioners for information on the health of children older than seven years of age:

Doctors can understand everything because he/she is educated and he/she has studied a lot in this regard. They have heard health discussions… No one else except doctors can treat our diseases. (Female School-based Youth, Nangarhar, IDI 49)

While doctors and other health care providers were the preferred information source, participants (particularly male youth) reported internal barriers to discussing some health issues with them:

I need to learn more about issues of pregnancy, reproductive health and child care. I and friends don't feel very comfortable to share these issues with a doctor but it is very good to learn about this issue. And sometimes even some of the doctors may not want to talk about these issues with youth. (Male School-based Youth, Herat, IDI 39)

The second most trusted source of health information was television. Participants said they can get good information on different health issues and can understand the issues clearly because the television medium has a visual component, making it more powerful than radio. Other trustworthy sources mentioned by some participants were teachers, books, Internet, radio, religious leaders, and family members.

The least trusted sources were radio, Internet, and mobile vaccine teams who do not carry medical ID cards (as some participants believe them to be imposters who may harm their children). We acknowledge some of these sources appear on both lists (i.e., the list for most- and least-trusted sources), and participants would qualify remarks that Internet sites from known reliable sources like the MOPH could be trusted but that Facebook and other social media sources could not. Some participants shared their reasons for not being able to trust information from the radio:

We can only hear health care information from the radio, but we don't know who had said it. Is it an expert or not? (Female School-based Youth, Balkh, IDI 15)

Health Issues About Which Participants Want More Information

Health issues for which participants desired more information included various aspects of maternal health and how to have a successful pregnancy; well-baby and child care, with particular emphasis on immunization and nutrition; RH, specifically FP, menstrual disorders, and health risks associated with early marriage; hygiene and infection prevention; and general health topics including malaria, hepatitis, gastroenteritis prevention and treatment, and management of depression and stress.

Most male participants (both youth and adults) were interested in receiving more FP/RMNCH information on how they could best care for their families, potentially reflecting the male role as household health decision maker:

A father or a husband must know all the information about a child's health and the mother's health. They must know how to instruct and raise their children. Besides, it is important that they should know how they can treat the mother and child after the child's birth. (Adult Male Farmer, Takhar, IDI 5)

Our youth want to have enough information about reproduction because everyone has a wife or they want to get married. So, living without having this kind of information is difficult. (Male School-based Youth, Herat, FGD 7)

Several male youth specifically requested the need for information on reproductive anatomy and physiology, stating that they needed to be prepared for marriage. The following scenario reflects social barriers to discussing sexual and RH issues through interpersonal communication, present even among educated youth. The scenario illustrates why there is a perceived need for this information, but selecting the appropriate channel may be problematic:

I want to learn about how a young person can marry and create a family. [Sessions recorder: In this part, the interviewee's face went red. It showed some shame or some strange feeling he might have meant the issue of marriage and sexual relations of bride and groom. Some other interviewees were laughing too. Even participant 03 and 05 left the panel for one moment and went out]... (Male School-based Youth, Balkh, FGD 5)

Challenges People Face Obtaining Health Information

While participants from all groups mentioned lack of health facilities or providers and low literacy as common challenges to accessing health information, two additional areas emerged. All participant groups mentioned feelings of embarrassment or shame in soliciting health information through interpersonal communication. This situation was particularly compelling, as it creates an impasse for accessing information from a health provider—the reported preferred information source for most participants. Several male youth said they do not have the courage to ask questions about health and would feel shy, while others mentioned that discussing RH, including pregnancy topics, was particularly embarrassing, especially with health care providers:

It is because they are shy and that is how they cannot share their health problems with a doctor. Also, they are afraid of their friends, they think if they share their problems with someone, their whole community will make fun of them. (Male IDP Youth, Kandahar, IDI 34)

Men mostly feel shy. It's common in our community. Especially when people know the doctors, they tend not to refer to them. They prefer strangers. Doctors that they don't know. We have a doctor in our clinic who is from our own community. He is a specialized doctor. He has seven years of education, but people tend to refer to a nurse who has only two years of education. They refer to the nurse for serious sicknesses. It's because they have known the doctor for two years. (Adult Male Community Leader, Herat, IDI 44)

The second notable theme was the existence of gender-based barriers to health information access at individual and household levels, which youth acknowledged and male participants described as normative. The following quotes illustrate household-level decision making that impairs access to information (but are also barriers to care):

Permission could not be given to female youth to step outside the home, because this is a Pashtun community, and they consider it bad for themselves when their girls step outside of their home. And for boys, there is no problem to go outside, but this is the major problem for girls and young women to go somewhere. (Female School-based Youth, Nangarhar, FGD 10)

People here observe their community's bad traditions rather than looking to Islamic sayings, and that is why they are telling their daughters to stay in the home. Even if their daughters have any problem or sicknesses, the parents say for her to be patient and everything will be fine, because they cannot take their females to the male doctors. (Female School-based Youth, Nangarhar, FGD 10)

Sometimes women do not share their pain or illness with their husband or family elder because they are afraid of the culture and family situation. Some people in our area avoid getting close to a person who is very sick, fearing the disease will get to them even if the disease not contagious… There is a problem in our community that if a woman becomes sick quickly, then they call them "sick women." That's the reason that most of women do not share their health issues on time. (Adult Male Community Leader, Herat, FGD 9)

Many male participants were uncomfortable speaking with health care providers about RH issues, while women were comfortable speaking to a female but not a male doctor. Male youth also mentioned being uncomfortable discussing drug addiction, mental health issues, puberty, and masturbation. Participants said they were comfortable speaking with health care providers of the same sex about common illnesses, such as high blood pressure, high cholesterol, stomach ailments, arthritis, sore throats, and topics related to health promotion and disease prevention.

Health Care Access

Health Care-seeking Behavior and Challenges

Participants were asked where they go to seek care when they or their children have a health problem; we did not specify the condition. Most participants said they go to a doctor or visit a health facility. Some said they use home remedies such as traditional and herbal drugs for treating diseases, while a few participants mentioned that they go to mullahs or obtain taweez to address their health issues. Several participants reported that they purchase drugs from pharmacies without a physician's prescription:

If I have money, then I go to private doctor. If I don't have money for doctors, then I go to drugstore and tell him that I got body ache, then he gives me injection or serum. (Adult Male IDP, Kandahar, IDI 38)

We prepare medication at home—Spirkai (a kind of herb). we boil it and give it to the sick child. (Adult Male IDP, Nangarhar, IDI 23)

Participants were then asked about the challenges they faced when seeking health care. Financial barriers were most commonly reported. Specifically, participants' inability to pay for prescription drugs and transportation from home to the health care facilities was reported in about half of the transcripts, predominantly by men:

It depends on family economic situations because some of the neighbors who live in Zargaran village (Bamyan), unfortunately, don't have a good economic situation. They will remain deprived from health, medicine, and doctors and from advices and taking medicines. (Adult Male Community Leader, Bamyan, IDI 11)

Most times people don't go to doctor and they deliver the baby at home. First problem is that they have economic problem. So, whether alive or death, they must do the delivery at home. (Adult Male IDP, Kabul, IDI 29)

Similar to barriers to accessing health information, women identified many challenges to seeking health care services, including difficulties related to their families hindering them. For some, the men in their families acted as gatekeepers, determining whether they are allowed to seek health care and from whom. This was especially difficult for those seeking ANC and FP services:

Interviewer: *Are there in your village men who don't take their wives to a doctor because they are ashamed?*
Participant: *Some of them may be like this. They say if we die, let's die at home, but we should not go to doctors. Going to doctors has caused women to get unveiled; for instance, they ask the patient to lay down (Khawchaly). It means to lay down in front of an unfamiliar man.* (Adult Male Farmer, Bamyan, IDI 9)

Most female students and IDP youth stated that the lack of female health care providers in their communities posed a major barrier for women seeking health care services, because most families will not allow a woman to be seen by a male doctor and most women would feel uncomfortable seeing a male provider:

In our society, this has been considered like a very bad action if a man asks about his wife's problem from a male doctor. In Pashtun society, it is a shame if someone shares his wife's problem with someone else. This has been a big problem in our society. It is because we do not have enough female doctors. Our mothers cannot easily go to doctors and if they go to male doctors while pregnant, they cannot share their problems with a male doctor. They are shy because they think, 'we are women, how can we tell our problems to a male?' and that is why they cannot share their problems with a doctor. (Female School-based Youth, Nangarhar, IDI 49)

Women cannot speak comfortably about this issue, particularly with male doctors because they would feel shy. It is really hard to discuss their problems with male doctors, especially the problems like child delivery, menstruation, and other diseases like this. (Female IDP Youth, Balkh, IDI 53)

When asked if they were willing to take their wives to a female doctor, nearly all youth and male adults responded affirmatively. They strongly preferred female doctors when it came to their wives' health issues:

We have a very traditional community, and always women in our community were under strict sanctions. Even when I am taking females to a doctor, I am feeling shameful. In our area, women are not given enough freedom. When a woman goes to a doctor, she will feel ashamed because doctors touch a woman's body. Women won't go to male doctor unless they have to, but with female doctors, they feel comfortable. I am feeling relaxed to take them to a female doctor. (Adult Male ANA, Kabul, FGD 11)

The influence of religious leaders was mentioned by a few participants as a potential barrier to health care. Mullahs reportedly give advice to the community, saying that women should not leave their houses under any circumstance and restricting them from going to health facilities:

Yes, the mullahs in our village mostly advise every morning, and they insist that the women should not go outside of the house in any circumstances. They say that these women are born in the house, raised, and then married in the house…The mullahs are against such things, even they are against going to the doctor. They say there was no doctor in the past, but the women delivered the baby at that time, too. The people would have been dying if there were no doctors. (Female IDP Youth, Kandahar, IDI 52)

Lack of privacy was one of the major barriers identified by school-based youth, male IDP youth, and men for seeking health care services for themselves. They were often shy or hesitant to share their health concerns with a doctor. They feared that their personal lives would no longer remain private:

Despite agreeing to see a doctor for their illnesses, men felt that they could delay their visits to see a doctor or a clinic unless they were very ill:

Men visit very little because it is an issue in all of Afghanistan that men are not interested to visit doctors and the hospital. They visit doctors when they have some serious illnesses or maybe they become tired

of that illness. When illness had more effect on them, then they refer to hospital. Therefore men are going to hospital very rarely. (Adult Male Community Leader, Bamyan, IDI 11)

While we did not formally inquire about perceived quality of health care, this theme emerged when discussing barriers. Quality issues in public health facilities were also reported as critical challenges in accessing health care. The most consistent theme regarding health care quality among men was lack of knowledge among doctors in hospitals and clinics. The men questioned providers' credibility, which led to an inability to trust them:

There are some doctors in our community who have studied in Pakistan for six months and now they give medicine to people. Most of our people do not trust them because they are not well educated in medical science. They have created problem for most of people because they have limited knowledge of medicine. (Adult Male Community Leader, Herat, FGD 9)

If you want us to talk about our experience, then we have to say that all these doctors sell medicines whether they are in Baharak District of Takhar or in Dasht-e-Archi District of Kunduz. We want such doctors that first find out what our sickness is and then give us medicine, and we do not have such doctors. Most of them are not proper doctors. (Adult Male IDP, Takhar, FGD 1)

Other quality issues included poor health care service provision, crowded health facilities and long waiting times, lack of medicines and supplies, providers' reluctance to answer clients' questions and provide information or advice, and the unavailability of providers during official working hours.

Many men and male youth perceived private clinics, as opposed to government health facilities, to be superior in quality for treatment, medicines, and behavior of doctors toward the patients. Though private clinics charged a fee, most participants thought it was acceptable as long as they received proper and respectful treatment:

We have said before, too. If you refer to private doctor, there is everything, they will respect you, give you the right decision, but in governmental clinics you don't have the permission to speak. (Male School-based Youth, Herat, FGD 7)

Health care providers' lack of professionalism was reported as a challenge, particularly by youth. This included providers' negligence and poor communication and rapport between client and provider. Health care providers were also reported to be rude and disrespectful toward patients, especially female, adolescent, and young adult patients.

I don't think that they respect the youth because they don't give them the opportunity to talk about their problems at the hospital and clinic. If you talk, they will say, 'When you know, why did you come to the hospital?' They make fun of the patient. (Male School-based Youth, Herat, FGD 7)

In government hospitals, there are issues that doctors do not behave well with women. For example, they shout at women, 'Why are you not clean, why you give birth to many children?' and so on. Some doctors threaten the patient. When doctors are fed up with patients coming from rural areas with odd clothing and odors, they react badly or ridicule them. (Adult Male ANA, Herat, FGD 11)

Many participants reported that health care providers demanded money in return for services in the public-sector facilities and gave priority and special attention to patients of higher socioeconomic status or those with familial connections:

When you go to these hospitals, they will behave very well with you if you are rich. Even they give their hidden medicine to people who are rich or to people who have contacts in there. There is nothing for poor people. Even if poor people go there, they will not be checked up properly. They might also be told, 'Go to some other doctor, we cannot cure you here.' (Adult Male Community Leader, Herat, FGD 9)

Among IDPs, some special circumstances were noted by men, who felt that living as refugees was a major challenge to accessing health care services. They also blamed unhygienic living conditions for the diseases for which refugees required care:

We are refugees (we are kings in our own areas). Here, we feel very downgraded... We pray that peace returns to our own town so that we can go back to our homes. The first reason is poverty, and also unemployment. We say we don't have money for medicine. We feel shy of the doctors, too. If we are in our own village, we know our friends there. They lend us 500 AFNs so that we can go to the doctor. If humans have money, they feel more comfortable... No one lends money here. No one lends us money at all. If someone has 100 AFNs on you, they come in the afternoon and ask for their money. (Adult Male IDP, Takhar, FGD 1)

Decision Making for Seeking Health Care

Male participants were asked about the decision-making process within the household when a person needs to seek health care. They said a person usually seeks health care only when the situation becomes dire, as many cannot afford to see a health care provider:

Normally, when people of our village encounter a health issue, no one is referred to the doctor or health centers until the side effects and symptoms of the disease are totally known, or the person is weak and can't stand. When illness forces them, then they refer to the doctor. I mean, when the situation of a patient is not too critical, people don't tend to go to doctor, expecting that they will get well soon. (Male School-based Youth, Balkh, IDI 19)

Security was also mentioned as a key factor when making decisions to seek health care. One male participant emphasized needing to consider recent terrorist attacks against health facilities when making this decision:

People and doctors are afraid of security threats. You can see recently that hospitals are under threat, and if the doctors do not feel safe, they cannot serve you well. (Male School-based Youth, Herat, IDI 39)

When male adults were asked who within a family makes final decisions regarding seeking health care, most answered that men (usually male family elders) do:

Most times we consult with family elders, this could be their father, grandfather, or elder brother. Anyone who is the eldest has authority in the family. (Adult Male ANA, Balkh, IDI 21)

A minority said that decisions could be made by a variety of family members. In many cases, family elders such as grandparents were consulted first, followed by parents, in order of seniority.

With regard to female health issues, some participants suggested that women should seek advice from female elders within the family, and that any decision would ultimately be made by the female elder:

If the issue is related to a man's wife's health, then we ask our wife to go and talk to the husband's mother and get her advice. So, whatever my mother tells her, my wife will accept and respect. Besides, in cases like this, we don't share the problem of our wives with our fathers or brothers, because we will feel shy about it. Only my mother or any other female member of our family will be able to know about the issue. (Adult Male IDP, Kabul, IDI 29)

Some male participants made decisions in conjunction with their wives. Wives were credited with being knowledgeable regarding issues relevant to the home, and therefore their input was often sought:

As far as I know, people consult with their wives in all matters. There are people who do nothing without consultation with their wives. Even if they want to buy one kilo of meat, they consult with their wife and ask her should it be sheep's meat or cow's meat. (Male Community Leader, Herat, FGD 9)

Not all participants felt that wives should be consulted, with one participant even strongly emphasizing that women should not be involved, due to men not being able to trust them and having to worry that they would gossip to neighbors about private household matters:

> *The reason is, women are not loyal, so no one should consult with his wife. Yes, there are a lot of women whom we consult something with, and they then speak about it with the neighbors, and the issue will then spread in all of the area. Some stuff should not be shared with women.* (Adult Male ANA, Kabul, FGD 11)

Communication Platforms for Health Messaging

Participants were asked a set of questions pertaining to communication platforms for health messaging. In this section, we have grouped the conversation around four categories: 1) preferred communication platforms for receiving health messages, 2) use of mobile phones to disseminate health messaging, 3) factors that may affect successful dissemination of health messages through mobile phones, and 4) methods to improve acceptance of receiving health messages on mobile phones.

Preferred Communication Platforms for Receiving Health Messages

Mass media

Most participants identified mass media, such as television and radio, as an effective way to disseminate health messages. Television and radio were identified as ideal modes for dissemination of health messages for some participants, as they felt that these modes could be trusted since they perceived that only experts would be able to disseminate information through them. However, opinions varied on which of the two was a better mode for dissemination:

> *People have access to radio, and we don't have TV.* (Male IDP Youth, Kandahar, IDI 27)

> *TV is good because it can be watched and all can see it. People might not listen to the radio much, but they will for sure watch TV. If it is a video, it will be a lot better, because people will be engaged in a video much more than voice. Every house can have a TV and watch it.* (Male School-based Youth, Herat, IDI 39)

The ability to ask questions of these experts while maintaining anonymity was a desired feature. The ability to listen to other listeners' questions and learn from their experiences, such as through call-in shows, was also deemed beneficial:

> *There should be a number on the radio to which people can call and ask about their problems. We can call the radio in private and ask about our questions. No one can see our face.* (Male School-based Youth, Balkh, FGD 5)

Mobile phones

Many participants also identified mobile phones as an ideal way to disseminate health messages:

> *Due to cultural barriers, we cannot receive some of the information from TV. So, it is better to receive that information through mobile phone, because everyone has access to phone and can check those messages.* (Male School-based Youth, Balkh, FGD 5)

In-person training

Many participants identified in-person trainings such as workshops, seminars, and meetings as one of the best ways to disseminate health messages within their communities. Participants suggested that these trainings could be held at local mosques, schools, or health centers and could cover such topics as FP, immunization, and ANC. In-person trainings were identified by some as ideal due to beliefs that mass media has limited reach; that individuals absorb more from trainings; and that these trainings would lead

to secondary transmission of messages, as trainees would relay new knowledge to others within their families and communities:

Workshops or seminars look good to Afghans. You inform six people, these six people then inform another six people, and then 18 and then 40. A workshop is better and there is no benefit in mobile phones. (Adult Male IDP, Nangarhar, FGD 8)

I participated in different discussions, and I like very much to discuss women's health. My friends and I decided to hold a project. We want to provide a central workshop for women to inform women about birth spacing and vaccination. Also, to discuss how they deal with problems during pregnancy. I think holding a workshop has direct effect. (Female School-based Youth, Herat, IDI 14)

Clerics

A few participants, mainly men and male youth, identified clerics as an appropriate way to disseminate health messages. These participants largely considered clerics and mullahs as important and respected figures in society and felt people would embrace whatever they said:

In a remote area, people usually trust their local elders or Madrasas 100 percent. It is good that a mullah or the mosque mention it to people. (Adult Male Community Leader, Herat, IDI 44)

If they send that information to us in the mosque or at university, then we can talk or share this information at home. Family elders go to the mosque, and they can hear from the mullah and share it. (Male School-based Youth, Herat, IDI 39)

Use of Mobile Phones to Disseminate Health Messaging

Participants were directly asked for their opinions regarding the feasibility of a program that would allow access to audio messages through mobile phones, specifically pertaining to FP, pregnancy, and other health concerns of youth. Many participants welcomed the idea and felt that the wide availability of mobile phones made it an appropriate tool for health dissemination:

The benefits of receiving health information through a mobile phone is that everyone has a personal mobile phone, and they can directly receive, listen to, and read messages in their mobile phone. (Male School-based Youth, Balkh, IDI 20)

It has many benefits. For example; if we want to have access to information which is in the village where there is fear of insecurity and economic problems, we can receive information through mobile phones without any fear. (Female School-based Youth, Herat, IDI 12)

I want to receive health messages through the phone, because all people have access to a phone. (Adult Male Community Leader, Herat, IDI 42)

While some participants highlighted that a mobile phone-based program would only benefit mobile phone owners, some participants felt it was possible for individuals with phones to share transmitted health messages with others who do not have phones:

Messages would help local people. When they listen to the information you have sent, local people would then share it with others who haven't received it. (Male School-based Youth, Nangarhar, IDI 26)

Some participants believed it was beneficial to disseminate health information via audio messages on mobile phones because it would save time and money that would have otherwise been spent visiting a doctor or health facility:

Youth can solve their problems without going out somewhere. It will prevent waste of money and time. It is very good. (Adult Male Community Leader, Herat, IDI 42)

It is a very easy way to get information. They don't need to go to a doctor or a community health care center to get such information. This is the easiest way health information can get to them. It is a good tool for all people because it saves their time. (Female IDP Youth, Balkh, IDI 53)

For several participants, such a program was seen as beneficial as it would allow individuals to access health information when needed. Unlike radio or television, which requires individuals to be present during a broadcast, phone messages allow individuals to access information at their convenience:
A TV program can last for 30 minutes, and if you miss it, you miss the information. However, you can access the mobile phone 24 hours. You can talk to a doctor and solve your issues. (Adult Male Community Leader, Herat, FGD 9)

Many youth commented that receiving health messages via mobile phone would help them maintain privacy:

Because nowadays every youth has access to a mobile phone. On daily basis, there should be three to four messages per day about puberty and its signs. It is not possible to send such information through TV because all would see that, so it is better to send it via phone message. (Male School-based Youth, Balkh, FGD 5)

Unlike television or radio, mobile phones were seen by one participant as allowing individuals to have two-way communication with a health care provider. While one could only watch or listen to health messages disseminated via television or radio, mobile phones would allow individuals to communicate, asking a health care provider questions pertaining to their specific needs:

*Because we can easily contact someone and we can solve our problems though telephones, we cannot share our health problems with someone through the TV. (*Female IDP Youth, Nangarhar, IDI 50)

While many participants felt that receiving health messages through mobile phones offered many benefits, some participants felt that other methods, such as television, radio, and workshops, would be more effective:

A face-to-face workshop is better because one can see everything through their own eyes, which is practical. Mobile messages are more like theory. You just listen to it and it will end. (Male School-based Youth, Nangarhar, IDI 26)

I do not support audio messages and calls, because the effect of audio messages is less than live or face-to-face programs. (Female School-based Youth, Balkh, IDI 13)

The majority in this area are illiterate. If you text health messages to them, they would not be able to understand it or read. (Adult Male Community Leader, Herat, IDI 46)

Many school-based youth agreed that universities and colleges were the best places to provide health information because of their ability to convey information with greater depth and to students disseminating the information within their social networks:

I think it is better to reach out to us through our university and teachers because this is safer and easier. TV and other media is not possible because due to cultural issues they might not discuss topics deeply in TV. (Female School-based Youth, Kabul, IDI 4)

In my opinion, in each institute there are a lot of people from districts and villages. If they give information for these young people in the center of city, it would be great because they can go to their villages and transfer information to people in villages and most people (in the village) don't have access to national and local media. (Male School-based Youth, Herat, FGD 7)

For other participants, using mobile phones to disseminate health messages was seen as a bad idea that would not be accepted:

I think it will not be acceptable because there are so many messages, which are frequently sent to phones. It won't look very important to people. All sorts of networks send their messages through phones. (Adult Male Community Leader, Herat, IDI 42)

Additionally, some participants felt that individuals would be too busy to accept such calls:
I must cultivate rice, green beans, okra, maize, and beans at the same time. I don't have time to talk with you. If I get your call, then I will not receive it. (Adult Male IDP, Nangarhar, FGD 8)

Factors that Would Affect Successful Messaging through Mobile Phones

Cost

Cost was highlighted by most participants as the major barrier to using this program. While many highlighted the need for such a program to be free, others gave various amounts they would be willing to spend on receiving health messages, ranging from 50 pols (1/2 Afs) per message up to 100 Afs (US$1.49). The main reason for lack of willingness to pay for such a program was the poor economic situation of many individuals:

Unavailability of money can make calling difficult for youth, because if you don't have money, then how would you get good information? (Female IDP Youth, Nangarhar, IDI 50)

A few participants said that willingness to pay would be based on an individual's need for such information:

The issue depends on how much a person is interested to receive health information. If a person is interested in receiving health messages, he is willing to pay the charges. (Male School-based Youth, Balkh, IDI 20)

One participant mentioned that if the cost of such a program became too high, individuals would rather spend the money to see a doctor in person:

From every 100 people, only two would be ready to pay, while others might think, 'If we need to pay 50 Afghani, why shouldn't we just pay it to a doctor?' (Adult Male IDP, Kabul, IDI 29)

Accuracy of health information

Some participants were concerned that health information shared through voice messages could be inaccurate. Not knowing or seeing the information source could lead to some not trusting the information:

*The only concern I have is the unknown information sources, because we do not know if it is a reliable source or not, is the information correct or not. (*Female IDP Youth, Balkh, IDI 53)

Other participants were concerned that many individuals would not use such a program, believing it to be a fraudulent program in which users pay money but receive low-quality information. Others worried that individuals would believe that a joke was being played on them, and that the personal information shared through the service could be compromised or publicized:

There are some people that deceive citizens. I have received messages that says you are the winner of some amount, and says to send them money, then we will be given our reward. (Adult Male IDP, Kandahar, IDI 38)

Local perceptions

Some participants commented that individuals using mobile phones may be perceived to be involved in inappropriate behavior. Therefore, family members, such as fathers and husbands, would not want members of their family to be seen using a mobile phone:

If there is a teenager in the family and he has a mobile phone, it doesn't look good to his father. How did he buy it? How does he use it? Does he use it in the right way or not? The majority of fathers don't

let their sons have a mobile phone, because they put immoral things in mobile phones. (Adult Male IDP, Nangarhar, FGD 8)

Male versus female concerns

Several female participants identified concerns about a mobile phone-based messaging program that varied depending on one's gender. While men are often concerned with the accuracy of information, women are often additionally concerned about their privacy:

Males are afraid of this unknown and the credibility of the source, but …women are also afraid of losing their privacy. This is the only difference between male and female youth. Credible sources and privacy are the most important elements for women. (Female IDP Youth, Balkh, IDI 53)

Methods to Improve Acceptance of Receiving Health Messages on Mobile Phones

Increase awareness of program and phone use

Participants had many ideas on how to improve the messages that would be disseminated through a mobile phone health program. Some said that before such a program could be initiated effectively, implementers should focus on educating communities on the value of mobile phones to transmit health information. Most participants felt that many individuals were concerned with increased phone use, and that phone use could lead to private family issues being exposed or youth accessing "immoral" materials. Some therefore felt that a campaign must first be conducted to address these concerns. For women to be allowed to receive health messages, the program would need to reach out to men, informing them that these messages are important and valuable:

It [the program] is possible, if first you make men aware about the value of this program. It should ask from people to share these messages with other family members, too. (Adult Male ANA, Balkh, IDI 21)

It is important to highlight that this program comes from the Ministry of Public Health. Knowing that this program is from the MOPH would lead to increased comfort, and would further encourage men to allow their family to access such a program. If attention is not paid to making sure people understand this program and its links to the government, they risk people not using it. (Adult Male Community Leader, Herat, FGD 9)

Target messages and improve content and user interface

Participants suggested that messages should be colorful, include various photos, use attractive wording, and use local languages. The content should cover multiple topics (not a single topic) that are of interest to clients, be comprehensive but not repetitive, and include topics that are usually difficult to discuss, such as sexual health. Source information would also need to be included so that users would be more likely to trust the messages. One participant also suggested including interesting facts not related to health as a way to build interest:

As these messages are about health, they will be interesting to all the people. But it will be better if the messages are in the form that the audience feels they directly need them for their health care. For example, sending a message like 'What to do to not become sick?' (Female School-based Youth, Balkh, IDI 15)

The messages should be simple so that everyone could get it. When people understand it, they would like it and would listen to it. (Adult Male Community Leader, Herat, IDI 46)

Many youth commented that the messages should be targeted to people by age group, due to disparate interests:

There should be a difference between the messages for young people and adults, because these two groups have different needs and they encounter different problems. (Male School-based Youth, Balkh, IDI 18)

A few participants commented on the need to make the user interface simple and readily usable by someone with limited exposure to technology:

When we call to 4040, then have to select the language by pressing button of your choice then connect you direct with the doctor and answer in a very good language. This is good and you can't make it more simple. The direct call is easy, and the other way is also easy, but some people don't know how to call, and which button to press. I also don't have much education, but again I am good. (Adult Male IDP, Nangarhar, IDI 24)

Improve women's ability to access mobile phone health messages

Most men mentioned that their wives either own a mobile phone or have access to one. They generally welcomed the idea of women receiving health messages through mobile phones. However, they insisted that if the calls or messages originated from a known source, then they (the men themselves) would feel comfortable and safe:

Some [women] have [phones] and some don't. Four of the women have a telephone from these eight families and they receive the calls from numbers they know, and know it isn't ok from unknown numbers. If it is specific number, then there is no problem. (Adult Male IDP, Nangarhar, IDI 24)

While participants agreed that it wouldn't usually be a problem for male youth or men to access mobile phone health messages, most stated it could be a problem for female individuals, especially due to limited privacy:

It is a little hard because there is a possibility that her husband, mother, father, and her sister will be next to her and they keep asking 'Who you are talking with? What movie do you watch?' It does not matter that you are married or single. If you are married, your husband asks questions. If you are single, your father or your brother asks. (Female School-based Youth, Herat, IDI 14)

Males don't have any problems, and they can have access to personal mobile phone. This is a small problem among females. It is possible that some families may restrict females having sufficient privacy for listening to health messages. (Male School-based Youth, Balkh, IDI 18)

Some men felt that women, who often stay at home, do not need access to mobile phones and that any access would only cause harm to the family. Men were concerned that access to mobile phones would lead to exposure of family secrets, immoral behavior, and shame for the family:

Women do not need phones. They do not even need to talk to someone. They even do not know phone and its buttons. Families do not let them, too. Her husband does not let her use a phone. Men will not feel good. Women will not be allowed to use the phone. Even if they use for one day, the next day there is a danger that [her] husband will doubt her. (Adult Male IDP, Kabul, IDI 29)

For women, it is challenging because some families do not agree with the idea that women can have access to a phone because they think it might be immoral or any social problem might be created, which could be bad for the honor of men in that family. (Adult Male IDP, Takhar, IDI 16)

Some men were also concerned that if women had regular access to mobile phones, men outside a woman's family would begin contacting her; this behavior is called "phone bothering" in Afghanistan and is often stated as a reason women will not respond to a call if they do not recognize the number:

As you know, there are rude people who call women and disturb them, and therefore, no one trusts to respond to unknown numbers. This health program should be introduced first through TV and radio. (Adult Male ANA, Kabul, FGD 11)

It will be great if a message is broadcasted through TV, radio, and mobile asking the brothers to avoid sending abusive messages, calling and talking to girls. Because of such youth, a girl is beaten and the family loses trust in her. (Female School-based Youth, Nangarhar, IDI 51)

5. DISCUSSION

This formative assessment was conducted with the intent of characterizing FP/RMNCH message exposure, associated knowledge, attitudes, and practices, and understanding messaging content and channel preferences among adult men and youth in Afghanistan to inform future programming.

We conducted segmented analysis within different sub-groups of the populations purposively included in this study to better define specific gaps, needs, and preferences to shape future targeted programming. We purposively selected IDPs as a sample population to better sample rural populations and, as such, cannot differentiate whether differences specific to this group or sub-populations within this group are due to origin from rural areas or from changes occurring during displacement due to armed conflict or natural disaster. That limitation stated, IDP youth differed substantially from those recruited at schools by tendency towards earlier marriage and lower educational attainment, particularly for female youth. These differences translated into some substantive contrasts in FP/RMNCH knowledge, health and gender attitudes, and by preferred content and channels for engagement on FP/RMNCH. In both youth groups, there were clear differences by gender and, for IDP youth, by marital status; as such, these characteristics were chosen for segmented analysis based on target audiences for FP/RMNCH demand generation and health decision-making capacity. Among adult males, similar differences in educational attainment and for knowledge, attitudes, and preferences were noted between IDPs and non-IDPs. We also segmented the adult male population by marital status; we assumed FP/RMNCH content was more germane to those with wives and children as nearly 90 percent of married men had at least one child.

This discussion section is presented according to the main study findings:

- *FP/RMNCH knowledge gaps and inaccuracies*: substantial FP/RMNCH knowledge gaps vary by audience segments and reveal pervasive paucity of specific information;
- *Access to information and factors generating or creating barriers to demand*: potentially harmful attitudes derived from cultural norms that create barriers to making informed decisions and accessing FP/MNCH care among men and youth, particularly female youth;
- *Considerations and barriers due to gender, marital status, and IDP status*: mismatch between providers as the preferred sources for health information and ability/willingness to engage in interpersonal communication with a qualified provider among men and youth of both sexes;
- *Preferred FP/RMNCH content, channels, and programming realities among audience segments*: relatively lower coverage of FP/RMNCH topics in current health messaging through media sources and sub-optimal inclusion of content on why care is essential or engaging key influencers to permit and promote access to care; and
- *Interest and potential acceptability considerations for mobile phone-based FP/RMNCH programming*: high reported rates of mobile phone ownership/access and general receptivity to health programming administered through mobile phones but requiring promotion and modifications to overcome barriers by audience segment.

FP/RMNCH Knowledge Deficiencies, Perceived Gaps, and Inaccuracies among Audience Segments

We considered knowledge gaps as representing insufficient detail to inform behavior change, self-reported lack of knowledge, or incorrect information relayed in responses. Some general knowledge gaps were apparent among segmented groups for many aspects of FP, maternal, and newborn care.

Overall, most groups had high rates of agreement with statements like whether it was better to deliver in a health facility or have at least four ANC appointments, but lacked detailed knowledge of critical conditions, such as being able to name warning signs in pregnancy. Across groups, female participants generally had higher levels of correct and detailed knowledge of maternal and newborn complications, maternal and newborn care, and FP issues than did both male adults and youth, potentially reflecting greater access to messaging through visits to health care providers and information passed through mothers and elder female relatives in preparation for marriage. One exception to this was CHX knowledge, which more youth and male adults mentioned spontaneously; this may suggest a specific messaging channel for this information that targets male audiences, such as prescriptions for CHX for which pharmacists and drug sellers then explain its use. For CHX, youth recruited in Kandahar had the highest rates of knowledge, and sex-segmented analysis revealed different potential CHX information channels by sex for both youth groups. Among female participants, education level did not affect knowledge levels substantially, except for knowledge around infant and young child feeding and LAM duration, newborn skin-to-skin contact, and timing of peak fertility. For FP knowledge, there was greater diversity in knowledge patterns by sex: males were more likely to have correct information about the lack of efficacy of withdrawal and know that hormonal contraceptives do not cause sterility, but female participants had higher knowledge levels around IUCD duration and resolution of dysfunctional bleeding. There were no common factors associated with increased odds of FP knowledge between male and female youth; most associations were statement- and sex-specific. The exception to this was a positive association between age and correct FP knowledge among school-based female youth for all statements. We suspect that information source differs substantially by sex: among school-based female youth, having seen a provider in the past six months, mobile phone ownership, and Internet use were associated with correct knowledge for most statements, while these channels were only associated with correct knowledge of IUCD duration among male youth. Among adult male groups segmented by marital and IDP status, no factors (particularly radio use and seeing health providers) were consistently associated with FP knowledge, and significant variations in knowledge levels between provinces were noted.

FP/RMNCH knowledge measures were generally higher for male youth than for male adults across most content areas. Levels of correct maternal health, FP, and CHX knowledge were similar between male IDP and school-based youth, but knowledge measures concerning exclusive breastfeeding and infant and young child feeding duration, ways to keep neonates warm, and peak fertility timing were higher for school-based youth than for IDP male youth, potentially reflecting greater access to information sources, particularly those requiring higher literacy levels, such as books and the Internet. IDPs may be exposed to new information sources during the displacement process, particularly for groups moving from rural to urban and peri-urban settings.

Across groups where analysis was segmented by marital status, married individuals had higher levels of correct knowledge for nearly all FP/RMNCH content areas. Among IDP youth, female youth were more likely to be married, which may be partially responsible for the difference. However, married men were more likely than unmarried peers to have correct FP/RMNCH information for nearly all measures, which may reflect access to information sources as well as perceptions around relevancy of such information. However, even levels of correct knowledge that were relatively higher among married men were still generally lower than they were among IDP youth, particularly for detailed knowledge measures.

Across male adults, there were high levels of agreement about certain care access issues (e.g., delivery in a facility), but agreement around other care access issues (e.g., whether ANC was indicated when women felt well) was lower among some adult male subgroups, specifically IDPs and participants from Nangarhar and Balkh. This trend may reflect an unwillingness to engage in care unless potentially life-threatening conditions arise, noted in a qualitative study assessing the CHW program.[23] However, the significant negative association between IDP populations and agreement with need for ANC may denote mistrust or lack of awareness for how to access local health facilities, or lack of economic resources to do so. Though ANC and, specifically, four ANC visits were noted to be among services with the greatest disparity by wealth quintile in national surveys,[24,25] household income was not significantly associated with disagreement surrounding need for ANC among women who were not considered ill. For delivery services, province (i.e., Kandahar, Bamyan) and education (represented both by formal education and by reported Internet access) were strongly associated with preference for facility-based delivery; wealth quintile was negatively predictive of preference for facility-based delivery at the highest level, in contrast to findings for facility-based delivery and wealth status from nationally representative surveys.[24,25] This difference may be attributable to inaccuracies in income reporting, as we only considered reported household monthly income in this analysis (rather than a composite measure as used in national surveys. Further, we analyzed stated intentions rather than active use of services.

We also considered stated lack of knowledge and found high rates (up to 75 percent) of self-reported lack of knowledge about FP across all groups. Among youth, self-reported lack of knowledge approached or exceeded 25 percent for topics including complications during pregnancy and childbirth overall, life-threatening conditions among women ages 18 years or less during pregnancy, umbilical cord care, and FP knowledge for most of the groups in segmented analysis. This lack of knowledge was also detected for HIIs, such as CHX use for umbilical cord care and delayed bathing and skin-to-skin contact in newborn care. Of note, other HIIs, such as misoprostol use for postpartum hemorrhage prevention and kangaroo mother care for neonates with low birth weight, were not specifically queried.

For most topical areas, stated lack of knowledge was more common among male youth from both groups, who disproportionately responded “don’t know” or declined to respond due to the sensitive nature of the topics, especially for FP.[26] For this reason, we limited FP knowledge analysis to married IDP youth only. However, among school-based youth, most were unmarried and most also provided responses to FP knowledge questions, reflecting differences in comfort levels discussing FP/RMNCH knowledge. Rates of stating no knowledge were lower among married IDP youth for most content areas, either through permitting them to speak about these topics more freely than their unmarried counterparts or through having direct personal experience with these conditions.

Female youth from both groups, married youth, and all male adults were generally less likely than unmarried male youth to state not having knowledge for most measures. The few exceptions to this were that female youth claimed lack of knowledge more frequently than their male peers for some FP knowledge measures (e.g., efficacy of withdrawal) and were more likely to decline to answer the question. Further, female IDP youth had lower rates of reported lack of knowledge than their school-based counterparts, potentially reflecting that half were married and likely had received more FP/RMNCH information from health providers, female relatives, and other interpersonal sources. However, the proportions of IDP male youth and school-based male youth reporting no knowledge were similar, possibly reflecting similar barriers to exposure to preferred RMNCH information channels, such as health providers.

Our data suggest that female youth receive greater FP/RMNCH topical breadth in counseling and that this may be driven by greater exposure to health providers (particularly for FP/MNCH care) by social expectations that girls marry and have children early in life and need this information, or by discomfort either of male youth in requesting information about these topics or of providers in discussing these topics

with young men, particularly those who are not yet married. Qualitative data support these hypotheses, as several male youth from both IDP and school-based groups perceived being underinformed and mentioned being unable to access or ask about RMNCH information from a credible source despite their perceived need for this information to be prepared for marriage.

Adult men had similar or higher levels of stated lack of knowledge for most RMNCH content areas when compared with youth. Married adults had much lower stated lack of knowledge for most measures, whereas IDPs had similar levels compared with non-IDPs, except for early initiation of breastfeeding and LAM duration. When stated lack of knowledge was considered with correct knowledge levels, adult men tend to have general familiarity with various FP/RMNCH topics and seem willing to acknowledge lack of information about specific content.

In considering knowledge, incorrect responses were also assessed to determine for what content areas misperceptions may be prevalent and among which groups. There was pervasive incorrect knowledge regarding duration of infant and young child feeding and exclusive breastfeeding, which was more pronounced among male and IDP populations across groups and for unmarried adult men. Male adults largely had superficial FP knowledge, such as awareness of birth spacing as a concept and ability to name specific methods. Misconceptions about FP were also common; IDP status was not a consistent determinant of incorrect knowledge by group. Married IDP youth tended to endorse FP misconceptions at levels similar to or lower than those of school-based peers; we expected this difference since married youth have greater access to and social approbation for FP information through knowledgeable sources like health providers. Male adult IDPs endorsed FP misconceptions at higher levels than non-IDP peers; concerningly, married male adults were more likely than their unmarried peers to endorse several incorrect FP statements.

Men reported that the most frequent, convenient, and reliable sources of FP information were health providers and television; however, watching television at least weekly and having seen a health provider in the past six months were not consistently associated with correct FP knowledge. We believe this finding reflects a critical lack of detail in broadcast and counseling messages. Providers may not feel they have the time or have sufficient knowledge to provide comprehensive FP counseling to men and male patients may be too embarrassed or concerned about provider disclosure of their conversations to ask questions about FP methods during visits, as detailed in qualitative interviews. Based on qualitative inputs, men may instead turn to their peers or other sources (e.g., Facebook) for information, potentially resulting in less effective FP choices. This is reflected by the finding of increased odds of male individuals with any formal education being less likely to know that withdrawal is not a reliable FP method.

Gender and Social Norms Around Marriage, FP/RMNCH Information and Access to Care, and Impact on Care Utilization

Among youth populations, we explored norms and attitudes toward marriage and within marital relationships. Despite marital status (nearly half of IDP youth were married), nearly all youth participants were familiar with the decision-making process surrounding marriage and had some experience with negotiating an engagement. For entry into marriage, there were stark contrasts between IDP and school-based youth overall and, in segmented analysis, by sex for each group. Pursuing higher education and having a stable living situation clearly created different norms for marriage in some respects; less than 10 percent of school-based youth were married, with only a further 10 percent engaged, and much higher proportions reported having some role in choosing their own spouse, either by orchestrating their own match based on acquaintance or by being asked by their families for consent to an arranged match. Among married youth, very few chose their spouse, and one-third in both IDP and school-based groups met their spouse on their wedding day. Among IDP youth, more married male youth were asked whether

they agreed to the wife chosen for them by their families, whereas more married female students were presented with this option. This trend runs counter to qualitative data from 2009, when most of that study's participants stated that there was little solicitation of agreement by families from either party before betrothal, particularly for female youth.[27] However, the report suggested that increasing education among youth is changing this social norm, and our findings support this theory, as substantially more married school-based youth than married IDP youth were asked by their parents if they agreed to the selected partner.

Both groups of youth and both sexes within these groups had high levels of agreement that parental consent for marriage is required and that the ideal age of marriage is less than 24 years. Female youth from both populations strongly disagreed with very young age of marriage (e.g., before menstruation), which has been associated with cultural practices of *baad* (i.e., giving a girl in marriage to remediate a dispute) and *badal* (i.e., families exchanging girls in marriage for strengthened relations).[28] Among IDP youth, female youth had substantially lower levels of agreement than male youth regarding marrying at an early age (i.e., less than 18 years), though overall levels of agreement for both sexes were below 50 percent for most statements endorsing early marriage. These trends further suggest social norm change, potentially due to increasing messaging surrounding the risks of early marriage and childbearing.[26,27]

While most youth disagreed with early marriage, youth did largely agree that marriage before 24 years of age was preferable to marriage after that age. This agreement level was higher for female than male youth, likely reflecting social expectations that women be engaged or married by 18 years of age unless there are compelling circumstances for delay, such as finishing school. Young women themselves may have internalized the concept of *dakter torshi* (i.e., literally "picked girl"), a pejorative term for an unmarried woman in her mid-twenties and beyond that implies a negative reason, such as personal or family dishonor, that she has not been matched in marriage. Given these persistent norms around appropriate age of marriage, corroborated among adults in a national household survey,[13] efforts to promote delaying marriage for health reasons should focus on both youth and their parents and other familial key influencers. There have been mass media campaigns around delaying marriage, and efforts are underway to change national law to increase the minimum age of marriage for women from 16 to 18 years, which is the current minimum for men. These laws are difficult to enforce, and recent data indicate more than 10 percent of girls are married before the age of 16 years.[13]

In our study, only IDP youth were segmented by marital status; married youth were more likely to agree that women should be able to choose when they marry and that young people should have some choice in their spouse and be acquainted with him or her prior to marriage. This difference may reflect difficulties encountered early in marriage, as newly married couples contend both with a tremendous change in environment and social expectations and with having to establish a productive relationship with a new spouse. Thus, beliefs that a pre-existing friendship can ease this process may be more prominent among married youth.

We also assessed attitudes and social norms for gender equity in marriage among all populations using questions regarding scenarios where IPV, specifically wife beating, is acceptable from the Demographic and Health Survey.[3] Among youth populations, there were notable and unexpected differences by sex for both groups for most questions, and by marital status for IDP youth and male adults. One example is the generally higher levels of agreement among female youth than among male youth that a man is justified in beating his wife in four of five provided scenarios. This trend was consistent across IDP and school-based youth, though with lower proportions among school-based youth and among the surveyed youth and male adults males than among adult men and women surveyed nationally in 2015.[3]

The reason proposed for higher levels of agreement among female than male individuals is socially desirable response. Based on subject-matter expert opinion, male individuals wish to appear more liberal due to stigma associated with IPV, while female individuals wish to agree with what they perceive as community norms that validate their compliance with traditional values and thus their acceptability as women of virtue (personal communication, Sediq Seddiqi). Qualitative data provide insight into the hazards (to an entire family) associated with any loss of female reputation, even when an alleged incident is not due to any action taken or statement made by the woman, such as a broken engagement resulting from a wrong number call on a mobile phone.

We believe that the highest levels of agreement associated with beating a woman who leaves the house without permission also reflects this perspective. Married IDP youth were also more likely than their unmarried peers to agree with these statements, while married male adults were less likely than unmarried male adults to agree that beating is justified in all scenarios. This difference may reflect a more nuanced, mature view of a marital relationship. This difference may also be due to a greater representation of older and educated men within the married group, as these factors were associated with lower levels of agreement for several of the statements in subanalyses. Adult male IDPs had higher levels of agreement than their non-IDP counterparts and, while there were associations with age and province, there may be differences inherent to IDP status, such as the psychological stress of displacement and lack of resources, that lead to increased levels of IPV. In a study among school-aged children (ages 11–16 years) in Kabul, forced displacement due to conflict or economic deprivation was considered a major traumatic event, as was witnessing IPV.[29] Caregivers, who were usually parents of these children and exposed to the same traumatic events, also tended to have poor mental health based on self-reporting questionnaire-20 (SRQ-20) scores, and there was a strong association between poor child and poor caregiver mental health scores.[29] In this cohort, 83 percent of children reported displacement at least once; thus, it is probable that stressors incited by displacement make rationalization of IPV normative, both for male adults and for youth of both sexes.

Attitudes surrounding FP seem to have fewer established norms, as relatively large proportions (more than 20 percent) of male adults and IDP youth of both sexes stated they did not know if they agreed with FP-oriented values statements about the acceptability of a husband beating his wife. School-based youth were more likely to express agreement with shared responsibility for FP but also had high rates of agreement about perceiving that use of female-controlled FP methods would make women promiscuous. This reflected the need for gender-transformative messaging to reset norms that may not be as firmly entrenched as those around IPV, and to provide entrée to address more difficult norms.

Attitudes and social norms around FP/MNCH care and male involvement were also measured among all groups. Among youth populations, two distinct patterns emerged: disagreement based on sex and disagreement based on educational attainment. For differences based on sex, there were generally higher levels of agreement among male youth that men in their community visited health facilities to obtain ANC for their wives or to obtain FP with their wives, and that FP use and ANC were acceptable and readily accessible in their communities. This pattern may be attributable to socially desirable response, as male individuals may wish to endorse care seeking and approval for utilization of care among families in their communities. Female youth were more likely than male youth to disagree with women's ability to access care for themselves or their children, particularly among IDP youth. Female youth also had higher levels of agreement with statements regarding care to improve maternal and neonatal outcomes, such as going to a health facility in the event of complications during pregnancy or labor. This trend was consistent between female IDP and school-based youth and may reflect disproportionate targeting of FP/RMNCH messages to women or the transmission of knowledge from mothers, sisters, and older female relatives for marital relationship preparedness. There were few substantial differences between married and unmarried IDP youth, and most reflected greater perceptions among married youth that women face difficulty accessing

FP/MNCH care and appropriate nutrition during pregnancy and that their community would not approve of male spousal involvement in FP/MNCH care, potentially reflecting lived experience compared with unmarried peers. There were also differences based on education, with higher levels of agreement among school-based youth of both sexes for statements supporting the benefits of community support and the use of ANC, facility-based delivery, and FP services, potentially reflecting better economic prospects and higher educational attainment within these communities, more liberal views on female mobility, or both. The qualitative data suggest that there are few forums for community-based discussion on norms around FP/MNCH care and that peer- and home-based information sources tend to be most influential on shaping attitudes toward care.

Among male adults, a clear majority agreed with statements summarizing the support for and actions of both men and women in their communities to obtain ANC, delivery services, and FP from health providers or at facilities. The majority also agreed with statements regarding discussing FP use and facility-based delivery planning with their wives and mothers. There were few differences by marital status; however, even though the majority of adult male IDPs agreed with most statements, they were less likely than non-IDPs to agree and more likely than non-IDPs to state "neutral" feelings with most statements. Overall, most men agreed they felt confident and knowledgeable discussing birth planning and FP with their wives, despite the high proportion with lacking or having incorrect FP/RMNCH knowledge. It may be possible that this confidence results from spousal joint decision making, as two-thirds of men stated they make household economic and health decisions in consultation with their wives. Joint decision making was consistently significantly associated with older age and rural domicile, while male IDPs were much less likely than male non-IDPs to report joint decision making. We posit that these associations are present for the same reasons that older age and non-IDP status are associated with not endorsing statements that condone beating one's wife.

Many men discussed the importance of their wives' opinions and knowledge regarding health information in the IDIs. However, in several qualitative interviews, ultimate decision-making power was described as resting with the eldest male individuals in the family, which may have influenced the relatively heterogeneous response to statements regarding perceived difficulty for women to access ANC, FP, or delivery care or for to access health care for neonates. Men were also more likely to endorse beliefs that male peers in their community should be involved in their wives' care during pregnancy, facility-based delivery, and FP use, but they were mixed in their view of whether their community overall believes it is appropriate for husbands to be involved in FP or pregnancy care for their wives. These attitudes are consistent with concerns surrounding gossip about a person's family, particularly the female members, mentioned frequently in qualitative interviews; these attitudes also indicate a resultant need to adapt social norms to effect lasting behavioral change at the community level.[17] There were seven statements for which there was no clear majority agreeing or disagreeing across all male individuals, regardless of marital or IDP status. These statements focused on perceived difficulty for women to access FP/MNCH services and the community disapproving of a husband's involvement with their wife's pregnancy or FP decisions. In detailed analysis within groups segmented by marital and IDP status, level of agreement varied significantly by province and, for many of the statements, was lower for men who reported prior Internet use, joint spousal decision making, and watching television at least weekly across all segments. These trends likely represent the strength of local culture to establish social norms and some forms of media either representing or influencing greater FP/MNCH care engagement and resistance to pervasive community norms. The lower rates of agreement for several statements regarding joint spousal decision making may also reflect resistance to gender norms. Further research among these populations is needed to better delineate whether spousal dialogue and joint decision making lead to an enabling environment to access care and, if so, what interventions could foster this dialogue.

FP/RMNCH Information Channel Preferences and Mismatches between Preference and Engagement

Among all populations, health providers were generally regarded as the most accurate and preferred FP/RMNCH information source, with school-based youth also mentioning teachers. However, only half of both youth groups and 35 percent of male adults had seen a health provider in the past six months, and qualitative interviews revealed individual, community, and structural barriers specific to each group in accessing health services. While participants who reported a recent health provider visit stated that health counseling was part of the visit, counseling largely focused on preventive care and did not frequently include FP/RMNCH topics, particularly for male adults. Adult male IDPs and married men had somewhat higher rates of visiting care providers and also reported somewhat higher rates of receiving RMNCH counseling from this source than non-IDPs and unmarried men. Further, reliance on interpersonal communication for FP/RMNCH information for youth may be problematic, as social barriers prevent open discussion of FP/RMNCH topics among unmarried youth. This is particularly a problem for male youth, who reported that they resorted to peer networks or the Internet for information and had concerns regarding the quality of the information and consequent preparedness for marriage.

Among school-based youth (particularly female youth) and adult male non-IDPs, television was viewed at least weekly by 50 percent of participants and was the predominant FP/RMNCH information source for these groups; a higher proportion of viewers reported viewing health information broadcasts than reported listening to the radio, consistent with national ratios reported in a 2010 media survey.[19] Television was considered to be an accurate information source, particularly for FP information, and part of the credibility given to broadcast health information is that it is government-approved and, more importantly, viewers can see the source who is providing the information. Qualitative interviews revealed concerns regarding the accuracy of information coming from radio or mobile phone calls, as clients are unable to see the speaker and then judge the value of the content based on speaker credentials. Media access is particularly important for many female youth whose families have invested in television or radio, as they reported greater radio and television exposure, likely reflective of their time spent in the home and potentially contributing to higher levels of FP/RMNCH knowledge among female youth.[22] In this survey, media access was higher for school-based youth, possibly reflecting greater economic means and stable housing. Media access is also a concern for IDP youth and male adults, who have lower rates of radio and television access, have low literacy rates, and marry at young ages, and hence need reliable FP/RMNCH information sources at a younger age.

Adult male IDPs indicated reliance on peer and family networks for information, potentially reflecting low mass media access. Female IDP youth mentioned preferences for radio and television as health information channels, but their access to these channels was lower than for male peers and did not vary by marital status. This preference may reflect reduced mobility outside the home and thus inability to visit a health care provider on demand. Female school-based youth also preferred mass media channels as a FP/RMNCH information source after health care providers, and reported greater access than their male and female IDP counterparts. Even with limited access, mass media exposure and mobile phone ownership were positively correlated with knowledge levels for CHX, breastfeeding, or correct FP knowledge among some youth segments. Male adults and IDP youth also mentioned CHWs as a convenient and reliable source for health information, consistent with the self-identified role of CHWs.[23,30] However, only 29 percent of male adults had met with a CHW in the past three months and, as CHWs are located within the same community and social networks and tend to conduct group information sessions due to time constraints, social inhibitions described in the qualitative interviews may have prevented detailed coverage or requests for counseling regarding FP/RMNCH topics.[23,30] The need for communication from a reliable information source with a visual component is clear across all groups. However, the requested approach to increase community-based forums for women and men as per the qualitative interviews

may not be possible in the current context of limited resources, security concerns, and social norms that prevent direct communication with local sources.[30]

Women face additional barriers to both FP/RMNCH information and care, many of which were described in sex-based differences among youth in attitudes surrounding care access and utilization within their communities. These constraints were somewhat less pronounced for married female individuals, based on data from segmented analysis of IDP youth and some qualitative responses, though most qualitative statements made clear that married women still needed consent of a male gatekeeper within the family to access care. Female youth had higher levels of RMNCH knowledge for many topical areas and stated that they potentially had more resources for information within the family home, including both interpersonal communication from relatives and CHWs and from mass media sources. However, despite wives generally having higher knowledge levels, male adults stated that their wives very rarely made economic or health care decisions by themselves, though a higher percentage of men surveyed in this study reported joint decision making with their wives when compared with men in a 2015 national sample.[3] Around 10 percent of married male adults surveyed reported health decision being made by someone else in their household, rather than by the participant or his wife. Qualitative data further elaborated hierarchical decision-making practices in which final determinations are made by the eldest male individual or, occasionally, the eldest female individual in the family. This additional layer in decision making may have resulted in the relatively lower proportion of men reporting their wives delivering at a facility in the past 24 months when compared with those married men with children born in the past 24 months who endorsed facility-based deliveries in the knowledge section.

Though assessing perceived quality of care was not an aim of this evaluation, it bears mention that participants have, at best, a mixed view of health care providers. While health providers were largely seen as the most convenient and accurate health information source and visits to facilities were valued by youth and male participants for themselves and their families, the qualitative data frequently relayed examples of provider neglect for counseling or lack of fundamental knowledge. Many participants disclosed that providers would not provide counseling due to stated time constraints or would only provide the requested information or care if their services were sought through a private venue. There was also doubt cast upon diagnoses requiring medication, as some described profiteering by providers who referred patients to affiliated pharmacies. Other participants described conscious avoidance of local facilities with a preference for urban venues where they were not known to the provider and thus were not worried about disclosure of their condition or information to others in the community. Inability to find facilities with female care providers was also described as a barrier to receiving health information from providers, particularly by female youth who mentioned needing reliable information for menstrual problems and difficulties convincing their families to allow them to see a provider. Most of the care sources described were within the public sector, but there was blurring of divisions between public- and private-sector care, as providers worked in both settings and were said to refer patients from public-sector facilities to their private practices based on perceived ability to pay. The preference for and perceived higher quality of private-sector health services in Afghanistan has been documented,[11,24] but there is relatively less data regarding fluidity of providers common to both systems and differences in care provision based on location. Dual public- and private-practice patterns have been noted among midwives in Afghanistan and should be further assessed among primary care providers. This will help determine whether there is differential counseling between public and private sectors and potentially help frame interventions within evolving public-private partnerships.[6,24]

Suboptimal FP/RMNCH Content, Channel Coverage, and Comprehensive Engagement of Target Audiences and Key Influencers

Ensuring comprehensive subject coverage is one component that drives demand for health services and relies on accurate information tailored to specific audiences through multiple channels with repeated exposure.[31] Overall, all participant groups reported some exposure to health messages through various channels, with immunization and handwashing/hygiene among the most frequent topics. However, the previously discussed knowledge gaps suggest that current message content is not sufficiently detailed; the content may not resonate with or reach specific target audiences, like men; and populations may not be exposed to enough channels to reinforce messages and thus promote behavior change. Based on awareness and knowledge, particularly among male individuals, some FP/RMNCH information is being conveyed, but the level of detail is not sufficient to ensure correct knowledge and, potentially, confidence in decision making. Male adults overwhelmingly believed they were at least partly responsible for health decision making in their households, but many felt that their knowledge level was insufficient to inform decisions or that financial constraints had greater impact on decisions than need for MNCH care. Similarly, male youth felt that they did not have enough information to enter marriage and were concerned that there was no reliable source for the level of information they needed that could be readily accessed.

With regard to suboptimal channel coverage, interpersonal communication with health providers or CHWs was the preferred source for FP/RMNCH information for all surveyed groups. Our data reflect relatively low coverage of primary and secondary audiences by most preferred channels for FP/RMNCH information. Health providers, CHWs, and television—the three most preferred channels for FP/RMNCH information among all surveyed populations—each have challenges that may prevent health topic coverage. Limited contact with providers and community-based volunteers was noted among both youth and male adults, and multiple barriers to accessing health care were detailed in the qualitative interviews. While men stated a preference for male facility-based providers or CHWs as health information channels, qualitative interviews revealed individual-level barriers to FP/RMNCH information and services; these barriers were due to male embarrassment and concern over loss of honor if they or their wives access FP/MNCH services or ask questions about these sensitive topics, as described in other Afghan contexts.[17] Further, health providers, particularly those in public-sector facilities, frequently manage outpatient and delivery units with high patient volume, leaving little time for thorough counseling. This rushed aspect of care diminished perceptions regarding care quality in the qualitative interviews and has been noted in other studies.[32,33] Additionally, for FP/RMNCH, men rarely accompany their wives into the examination area due to cultural norms surrounding sex segregation. Thus, men are likely not included in counseling efforts with providers who potentially have greater FP/MNCH expertise than those providers who care for men when they seek services for themselves. A project that included men in postpartum counseling found higher rates of postpartum FP use and lower rates of incident pregnancy in Kabul, but this model has not been widely replicated in other parts of Afghanistan.[34] Health providers themselves have knowledge gaps, due to either poor quality of pre-service education or lack of refresher training and professional development, identified by midwives and nurses in Afghanistan and other low-resource contexts.[32,33,35,36] There have been no systematic multichannel RMNCH-focused SBC activities targeting health care providers to date, but such activities should be considered based on FP/RMNCH channel preferences among the surveyed populations.

Home visits by CHWs were requested by both adult men and youth, particularly IDP youth, as a preferred communication channel; however, only one-third of adult men reported any contact with a CHW in the past three months. CHWs are present in many communities and play an increasingly important role, as long distances to staffed facilities and insecurity limit options for rural populations. Expanding workloads, disconnects between CHW capacity and community expectations, and competing home or occupational responsibilities for these volunteers have been identified as barriers to CHWs providing counseling and

care; calling for more home visits or community-based sex-segregated workshops may not be feasible in light of existing demands on CHWs.[23,30] Further, concerns about seeking care or asking about sensitive FP/RMNCH issues from providers who live in the same community may limit information relayed through CHWs due to individual barriers at the participant level, despite CHWs being named as a preferred information channel.

Mass media may be a viable option, as several FP/RMNCH topics, including potentially sensitive issues like FP and delaying early marriage, were heard by participants on the radio or television. Television was a preferred information channel, particularly for female youth. However, the relatively low rates of television viewership among IDP youth of both sexes, who are predominantly rural, displaced, and economically disadvantaged, and among male adults may limit message exposure. Radio was more widely accessible to the participant population, reflecting national household ownership and use statistics.[3,13,19] However, participants tended to prefer messaging where the source could be visually identified, and the only mass media channel with this capacity is television. Television advertisements and public service messages were recalled by participants and generally accorded a high degree of trust in the accuracy of the information, as government approval was assumed as a requirement before broadcast.

Television and radio should be retained as channels for sensitization and SBC, but messaging should be adapted to have more detailed content; to have multiple messages, each targeted to several different primary audiences, given the role of the husband as the primary health decision-maker; and have content that not only includes health information but also addresses harmful social norms or other barriers to seeking care with culturally appropriate and locally developed solutions. The detected knowledge gaps may reflect insufficient detail in messages; this gap is unlikely to be remediated solely in mass media messaging due to airtime costs, which make longer messages cost-prohibitive. Assumptions that target audiences will seek further FP/RMNCH counseling from health providers or CHWs mentioned by most mass media messages may be flawed based on previously described barriers to seeking or receiving health counseling from providers in facilities or the community.

Last, most current FP/RMNCH campaigns are general and do not target a specific audience. Health care providers concentrate predominantly on the female patient or caregiver, likely due to access, and appear to neglect proscribed social norms around household-level health decision making. A few interventions have specifically and differentially targeted men and women, with this approach successfully used to change social norms around birth spacing and increase FP use, but they have not been replicated at scale in Afghanistan.[18] There are other community-based interventions in Afghanistan that separately target male and female community members in deference to social norms, such as community-led total sanitation, but the success of this approach has not been clearly documented either for the intended outcome of eliminating open defecation or for gender-norm transformation through collaborative decision making within the community.

In reviewing the past decade of peer-reviewed literature, only one youth-specific intervention in Afghanistan was found targeting telemedicine for mental health, presenting intervention design only.[37] There may be other youth-targeted programs described in the gray literature, but the lack of an evidence base for best approaches to such programming were evident in qualitative data from youth populations. Our data and those from other studies clearly document different target audiences with separate and specific misconceptions or norms that need to be differentially addressed to improve use of FP/MNCH care.[38,39] Innovative approaches that allow home or private access to comprehensive messages are needed, particularly to reach female audiences, and topics for which participants identified a need for further behavior change programming include:

- Basic fertility and pregnancy information for youth and separate programming targeting parents and other key influencers on how to address these topics with young adults.

- Preparation for marriage and family health decision making directed at youth, their parents, and key influencers in the community (e.g., religious leaders) to explore and reset social norms around delaying marriage, spousal choice, and collaborative decision making between spouses.
- Care during pregnancy and recognizing and responding to danger signs.
- Reasons and solutions for overcoming barriers to skilled attendance at delivery and resetting social norms around collaborative decision making between spouses through use of a birth plan.
- Interventions to address prevalent misconceptions around infant and child feeding and care during the peripartum period, with audience segmentation to include husbands and mothers-in-law.
- Infant care including appropriate umbilical cord care, infant danger signs, and specific guidance around breastfeeding and complementary feeding targeting both parents and mothers-in-law.
- Information to dispel popular FP method misconceptions.
- Social norms around FP with endorsement of birth spacing by key influencers.

Perceived Feasibility, Barriers to Use, and Desired Features for Mobile Phone RMNCH Interventions

Mobile phone coverage and use continues to expand in Afghanistan, and the high rates of mobile phone ownership and access, even among IDP youth, are comparable to those reported in national surveys.[3,13] Findings are notable for high rates of willingness to use a mobile phone-based FP/RMNCH information program, with three caveats. First, many participants noted that there should be no or minimal cost for the service. Economic constraints were noted for many aspects of health, principally for accessing health services, so it is not surprising to see this concern raised. Additionally, a national 10-percent tax was introduced on mobile calls in 2015. This resulted in a decrease in people using mobile devices to obtain information, from 57 percent in 2013 to 43 percent in 2017, which may have influenced concerns over cost.[13] Next, there were individual and community barriers to women, particularly young women, using mobile phones, with these barriers being more rigid in some provinces and in rural settings. Both women and men mentioned limitations on mobile phone use for young women and for wives, based on concerns related to family reputation and perceived need. However, when a prospective FP/RMNCH program was presented, male adults were quite receptive and suggested using mass media and community-based forums to advise men (who usually control mobile phone access within their households) that the program exists and the associated number. Once advised, male adults and many youth participants believed that men would then allow their wives or daughters to call that specific number and that the men might even join them for calls, potentially facilitating collaborative decision making within couples. Last, many participants preferred calling a live operator or call-in center for interpersonal communication and counseling tailored to their needs, rather than having one-way communication. One mobile network operator, MTN, has a fee-based call-in health service in Afghanistan, although a lapse in funding and building damage in a security incident have disabled the MOPH-operated call-in center. This reinforces the need for a revenue source to ensure sustained staffing and server performance and a promotions campaign to ensure a steady client stream, which may be best served with a public-private partnership. We did not explore participant awareness regarding costs and training associated with live-agent calling or community workshops, which are the other frequently mentioned desirable channel for FP/RMNCH information. Programs that require clients to act rather than receive “blast” messages were also seen as preferable, as they addressed the main complaint of mobile messaging programs I which people receive many unsolicited text and voice messages from mobile network operators. Identified advantages of mobile phone programming included low cost, confidentiality, and convenience, particularly in comparison to facility-based services.

Limitations

This study’s findings should be considered in view of certain limitations, in addition to those limitations already described. The study used mixed methods to assess sizeable selected populations across geographically and ethnically diverse areas. The qualitative interview process was iterative in some

respects, as transcripts were reviewed and a second question session may have been required due to inadequate probing. There were also low numbers of qualitative interviews across participants from specific audience segments (e.g., married female IDP youth) that cannot sufficiently ensure all themes were elucidated.[40] Some early qualitative interviews were rejected due to low quality, and interviewers were retrained or replaced to improve interview quality. Thus, the qualitative data should be regarded as a tool to enhance and explain some observations but likely do not fully characterize a cultural domain.

This study sampled male adults and youth of both sexes, and it employed a purposive approach to access organizations or areas where each target group was likely to be present. These locations were largely confined to urban areas where target group members were present in large enough numbers to ensure that the planned sample size was achieved. Due to need for time and cost efficiencies, multiple venues were sampled and a convenience sample was taken, as the total target-group populations for specified institutions or areas were not calculated.

For contextual correlation, we compared these study results to those of both non-representative and nationally representative studies. However, due to methodologic differences, our results cannot be considered representative of a given group overall or for a specific institution (e.g., GIHS) or subpopulation (e.g., IDPs). Because we chose secondary and health professions schools as recruitment sites, our school-based youth likely had a higher level of education and a concomitant higher level of knowledge of and access to media channels than other non-IDP youth. We employed random sampling techniques at specific sites to improve sample diversity and somewhat mitigate this issue. However, our study did assess male FP/RMNCH knowledge and messaging exposure to a greater degree than have national surveys,[3,5] and also recorded some of the first data for adolescents and young adults, particularly those who are not married. This provided valuable information regarding current and future health decision makers and consumers for SBC communication and care initiatives. Further, some topics queried were of a sensitive nature (e.g., FP), particularly for unmarried participants and in some areas of the country. As such, some questions had relatively high non-response rates (greater than 10 percent); those questions were analyzed to determine whether non-responders differed categorically from those responding, with significant differences noted where relevant. Thus, the information from those questions should be considered in light of skewed response rates.

Most nationally representative surveys limit participation to ever-married individuals ages 15–49 years, generally with single-source information on obstetric outcomes from married women of reproductive age.[3,5] Youth are generally not included in national surveys,[3,5] and there are few studies regarding FP/RMNCH issues among unmarried adolescents and young adults due to cultural sensitivities surrounding this information.[26] We purposively selected two separate pools of youth for our sample, with the hypothesis that these groups are quite distinct from each other and would have different priorities for health messaging and services, and in numbers sufficient to permit segmented analysis around major differentiators, such as marital status. Also, we included IDP populations for both male adults and youth to potentially increase representation from rural areas and to address the increasing numbers of IDPs in Afghanistan—a subpopulation likely needing targeted health services and approaches that differ from non-displaced populations. The IDP youth sample drew approximately three-fourths of the sample from rural areas, and the demographic features of this group are similar to those of rural populations in national surveys,[3] such as higher rates of unimproved household water sources and lower rates of television and mobile phone ownership compared with urban populations. For school-based youth, urban locations were not necessarily indicative of where a family home is located due to GIHS campuses nationally sourcing students, many of whom live in dormitories at the regional campus. However, the location of most of the sampled schools in urban centers may bias our results with under-representation of students from rural areas, particularly from secondary schools. Overall, neither sample can be considered representative of

youth in Afghanistan and we note the over-sampling for rural (IDP) and urban (school-based) locations may have resulted in potential bias.

Among male adults, half of the participants were sampled in rural settings, and a substantial proportion among those sampled in urban areas may consider their family home to be in a rural area due to inclusion of ANSF members, who report to urban settings for training and deployment, and of IDPs. The reported household water source and wealth indicator distributions were more similar to those for rural populations. However, television ownership overall was closer to that reported in the 2015 Afghanistan Demographic and Health Survey than for that in the 2012 Afghanistan Health Survey, potentially suggesting expansion of televised media availability in rural areas or sampling method differences.[3,41] Much higher proportions of men reported any formal education than in national surveys, in which 68 to 80 percent of men in the same age group as those within the interquartile range for our study reported no formal education.[3,41] However, educational quality was a concern noted for our participants, as literacy rates do not markedly improve until reported completion of at least three years of school—even with six reported years of education, 48 percent of our participants could not read a full sentence. We made a systematic error by having those reporting more than six years of formal education skip the reading test. Thus, we cannot comment on levels of illiteracy or low literacy among those reporting higher levels of educational attainment. However, these observations suggest possible inaccuracies in reporting educational attainment among participants.

An additional limitation was derived from all questionnaires being administered by trained data collectors, which may have introduced socially desirable responses. We believe this was particularly true for questions regarding IPV. However, due to low literacy rates among many participant groups and to cultural norms, we adopted administered interviews as a standard approach. There were also concerns about data consistency, as relatively high proportions of participants agreed with two seemingly disparate statements in the attitude sections, potentially reflecting respondent fatigue or poor understanding of the question. The instruments were pretested among at least 10 volunteers representative of each group, but this exercise may not have adequately captured question comprehension issues. Next, due to security incidents and seasonal closures, some originally planned survey sites, such as secondary schools in rural Takhar, were not accessible at the time of data collection and were replaced with urban sites, which may have led to over-representation of urban populations. For IDP groups, the definition of IDP was not standardized by period of displacement, and some individuals were included who had relocated more than five years previously, suggesting acculturation and adoption of perspectives similar to those of the district or city of residence rather than site of origin. We had intended for IDPs to increase representation of rural perspectives; thus, inclusion of longstanding IDPs in urban areas may have diluted this representation. Though there were very low refusal rates for participation, we did not collect data on those declining and cannot determine whether they were categorically different from individuals consenting to participation.

6. RECOMMENDATIONS AND CONCLUSIONS

Our formative research, conducted among male and female youth and male adults, explored their knowledge, attitudes, and perceived social and gender norms around FP/RMNCH information, as well as their exposure to and preferences for such information. This is among the first studies to characterize gaps in messaging content, perceived norms that create barriers to care and may be amenable to change, and service needs for these groups in Afghanistan.

Overall, the main findings reflect a pervasive lack of detail in messages; gender and social norms that prescribe decision making around, access to, and use of FP/RMNCH services; and suboptimal access to desired SBC channels. Because the populations included in this study are distinct from each other in their perceived needs and motivations for FP/RMNCH information and care, the following text begins with

general SBC recommendations to address issues affecting all populations, followed by specific guidance tailored to segments within each population.

Message Content and Channel Modifications

Disseminating FP/RMNCH information to the public is challenging, as the content should include sufficient reasons for inciting behavior change but also needs to be brief and easily understood by most target populations. Currently, most messages relayed through mass media and community-based channels (e.g., CHWs) are the same for all audiences and don't include action-based content (e.g., the warning signs of pregnancy and what to do if these signs are present). They also don't generally adapt messages to specific target audiences based on social norms and their roles in health decision making. As one example going forward, FP/RMNCH SBC programming that focuses on pregnant women and nursing mothers could provide information on individual-level actions, such as getting enough rest and eating iron- and folate-rich foods or taking those supplements during pregnancy, and why these actions are important. Similar messages would target mothers-in-law or husbands but with different actions and motivators. For mothers-in-law, this may include preparing specific foods and a recommended minimum number of weekly servings to ensure optimal child development and a daughter-in-law's rapid recovery from pregnancy. For husbands, messages might convey actions that direct which foods they should grow or purchase, or encourage them to take their wives for ANC and purchase supplements if recommended by the provider as part of their role as family protector.

Our data point to men taking actions based on their perceptions of what is needed, such as purchasing a baby's clothes. This reflects a willingness to act that can potentially be redirected through statements establishing rationale for and then specifying necessary action. Messages that spell out specific actions for optimal FP/MNCH outcomes should be developed and pretested with focus groups of each target audience in several geographically and ethnically diverse settings. This will help ensure that wording is correct, determine best channels for dissemination, and make sure that assumed decision-making roles ascribed to men are culturally congruent.

In addition to including greater detail, future FP/RMNCH SBC programming should address widely held misconceptions, such as those crediting withdrawal as being an effective FP method, in creative ways. Health care providers and teachers were widely described as being the most trusted source for FP/RMNCH information by surveyed populations. Thus, referencing the MOPH or an esteemed health professions school as the source of information, or having the messages delivered by a prominent health provider such as the president of the Afghanistan Midwives Association, would be an ideal channel to correct knowledge misconceptions, particularly surrounding FP and infant care and nutrition. For youth audiences, incorporating messages that counter misconceptions within songs, games, or school-based programming should be tested for feasibility and impact on knowledge and behavior. Multiple formats for messages and channels will likely be necessary to ensure the broadest reach and appeal to youth due to different norms for educational attainment and media access by sex, urban versus rural residence, and regional differences. Data reflecting messaging channels used by populations endorsing early marriage norms are illustrative for the wide range of channels that need to receive messaging on the same RMNCH content.[42]

Addressing Gender Norms in Content to Increase Male Inclusion and Female Agency

More critical in this environment is modifying message content and channels to address and, ideally, transform widely held gender and social norms that serve as barriers to improved FP/RMNCH. Despite analyses of gender and social norms conducted in Afghanistan over the past decade recommending that SBC should address harmful social norms,[17,26,43,44] there has been little formal incorporation of such

approaches in SBC content. Our data reflect several trends that could be incorporated into SBC content focused on FP/RMNCH improvement and approaches to transform critical social norms around decision making and agency within couples. One example is the need to equate care seeking, or at least conspicuous consumption of FP/RMNCH information, as an appropriate masculine behavior so that men will not fear stigma or derision for engaging in medical care or accompanying their wives to a health facility. Another example is publicizing an existing norm suggested by our study data, such as most male adults making major household decisions collaboratively with their wives.

These "facts" could be developed into a series of messages and approaches, adapted to specific target audiences, that celebrate men who engage in joint decision making with their wives and reflect national study data to suggest that many families use this approach. Separate messages would credit women with the decision making they routinely execute in their gendered roles (e.g., household "engineer" to manage food, clothing, and child care), to counter beliefs that women are not qualified to make decisions. A last component of this approach could have key influencers advocate that men will benefit if they "use two minds" and equate joint participation in decisions as consistent with masculine identity. We recommend that these programs start with content that is equally engaging for and seen more widely as a joint responsibility of both spouses, such as child nutrition and preparing for birth. The programs could then transition to topics perceived to be gendered, such as responsibility for and selection of FP methods and breastfeeding practices. Current gender norms also include addressing hierarchical decision making within households within each gender, and should specifically focus on mothers-in-law as a target group, given their influence over household health practices and their ability to influence their sons' decisions regarding health care for their wives.[43,44]

Norms for youth appear somewhat more flexible, as both our data and larger nationally representative studies suggest changing norms around ideal age for and agency in marriage decision making.[13] Youth also frequently mention having family members as health information sources and, for educated youth, being a frequent information source within their families due to their literacy and potential ability to access appropriate reference materials. Addressing social norms around youth agency, particularly around the timing of marriage and increasing decision-making autonomy for married youth, is needed and could be united into an SBC package for "marriage preparation" for engaged youth or "parenthood preparation" for young married couples. While the content for the packages would be similar for primary male and female audiences, a separate package will be needed for critical secondary audiences, particularly parents of the couples as well as community and religious leaders, to explain the benefits of understanding RMNCH as part of marriage preparation and to seek advocacy and support for the couple to execute their decisions around FP/RMNCH goals and care. Programming of this nature, which engages and informs young women and is endorsed by key influencers in the community, can transform how these young women are perceived in the household by mothers-in-law or husbands and thus elevate their agency to make decisions and reduce their risk of IPV. This transformation may also lead to enhanced engagement and efficacy in ensuring that women receive respectful care at facilities; the concept of self-care is promoted by the White Ribbon Alliance as part of an integrated response to improving the quality of MNH care.[45] Self-care relies on change at individual, community, facility, and policy levels; at the individual level, women develop health literacy and self-efficacy skills to improve birth preparedness and advocate for appropriate care at the facility level. Introducing this initiative would be feasible within marriage preparation or programming targeting young or first-time parents.

For young men, this type of package can reset social norms around age being a prerequisite for expertise and agency, and can provide more autonomy for marital and health decision making as well as reset existing gender norms around men accessing care. For male adults, particularly those in rural areas, SBC initiatives similar to The School for Husbands in Niger,[46] which frames RMNCH and nutrition decisions as part of a man's responsibilities in the home, may have a lasting positive impact. Specifically, this type

of program could transform norms around male facilitation of health-promoting household decisions, improve male engagement in facility-based care for self and family, and provide an entry point for promoting dialogue between spouses.

Improving FP/MNCH Service Demand through Access and Quality

Last, our data reflect a disconnect between desired and trusted SBC channels and access to those channels for many members of the target populations. Health care providers are among the most trusted sources of FP/RMNCH information for all groups, but there are numerous barriers to accessing a provider for information and care. We have discussed approaches to mitigate barriers created by gender and social norms that may allow more people to act upon their demand for services. There were two additional barriers described for not accessing care: insufficient facilities (particularly those with female providers) and poor quality of care from providers. Another key barrier to care was perceived lack of facilities with competent or female care providers within a reasonable distance, necessitating travel to district or provincial centers. Innovative public-private approaches, like Family Health Houses and *Khana Qabila*, are in pilot or early scale-up phases but may not be widely known outside their immediate communities. These ventures are staffed by midwives and represent a viable care option that might benefit from greater advertisement, particularly for facilities meeting a predetermined competence level. If such an approach were used through a branding mechanism, branded facilities could be advertised through interpersonal communication during community dialogue, through religious leaders, and through mass media at the provincial level to list villages and districts with branded sites able to provide FP/MNCH care.

Demand for services is also reduced by facility-based factors, as poor quality of care and perceived delays caused by lack of adequately trained female staff emerged as reasons for not seeking care. Participants frequently mentioned negative interactions with health facility personnel as a reason for not seeking care or for traveling to distant facilities, corroborated by other studies.[6,32,47] Thus, health care providers and students at health professions schools are an important target audience for SBC, both for providing and updating necessary information and for improving norms around respectful care.

For respectful maternity care, the White Ribbon Alliance provider training materials, adapted to the Afghan context, are being introduced for public-sector providers at pre-service and in-service levels. This initiative can be further enhanced through extension to private-sector providers and health professions schools, as well as through adaptation and implementation of media and policy-level advocacy for respectful maternity care to drive client expectations for quality services. The White Ribbon Alliance, the Healthy Newborn Network, and similar organizations have developed policy and media toolkits and community-level promotional materials to ensure multichannel promotion of respectful and high-quality facility-based care. The timing for such an initiative in Afghanistan may be ideal given the advent of the Sehatmandi project, which is anticipated to include performance-based financing (PBF) as a supply-side stimulus for quality care provision.[48]

Ongoing programs that engage both communities and facilities in addressing health issues, such as Partnership Defined Quality, may serve as an important and functional communication channel for improving service utilization and quality, with both the facility-based staff and communities in the catchment area having ownership of a mutually developed action plan to address identified problems. This process will leverage positive momentum from change at the community level and establish a forum through which the facility is held accountable to the community. It may be feasible to join such a model with nascent PBF activities to ensure routine inclusion of community feedback (rather than inclusion only during household surveys or exit interviews) and to relay positive facility-based changes rapidly to communities through social mobilizers and community leaders attending the meetings. This rapid information transfer may dispel negative impressions and thus barriers to engaging facility-based

care. This rapid feedback could then result in more visits and compensation through the PBF mechanism, creating a positive feedback loop. SBC for providers can include testimonials from peers linking improved service quality to increased PBF or fee for service, as well as update critical knowledge and skills for professional development.

Preferred Mass Media Channels and Optimizing FP/RMNCH Programming for Media

Mass media channels were also mentioned, and many participants stated that visual media were preferred to confirm source credibility. Television is an important channel, and access appears to be slowly increasing, making this channel a reasonable option for urban and peri-urban citizens. Programming that includes a medical provider as part of the messaging, either as the principle speaker in a brief public service announcement or as the last speaker who summarizes key points after "edutainment" (e.g., a call-in game show or dramatization), can leverage the preferred information channel in a medium accessible to a large audience. Youth participants, particularly female youth, were more likely to watch television, and program and messaging styles should reflect their preferences for viewing times and styles (e.g., preference for dramas over game shows). Involving these audiences in developing and conducting pretests with key segments of the audiences for both program content and promotional materials will increase the likelihood of exposure and engagement, particularly if there is an accompanying health provider or teacher discussion guide. We acknowledge that some participants stated preferring interpersonal communication with bidirectional exchange or that television is not financially or socially feasible for many members of target audiences, particularly rural male individuals. Further, airtime, especially during the target audience's peak viewing period of 6:00 to 9:00 P.M., is expensive and may not be feasible for longer programs (e.g., the serial *Khoshee*, which is a dramatization advocating for birth spacing). Creative solutions may include developing a public-private venture as part of a telecommunication company's corporate social responsibility program or enlisting advertising sponsors to defray the costs of airtime to enable the MOPH and partners to have sustained access to mass media channels. Radio appears to be less popular but is more widely accessible, particularly in rural areas. Target audiences for radio programming are mainly adult men. Programs should consider peak audience listening times and have call-in shows with recognized celebrities or authorities assisting with discussion topics that engage collaborative solutions to barriers to FP/MNCH care.

A new activity, the health video library, has been introduced as a pilot program in rural districts of Balkh, Herat, and Kandahar provinces and incorporates visual media to aid in interpersonal communication and motivation. This activity provides CHWs with tablets with focused video clips dramatizing RMNCH issues and information, such as appropriate newborn care including CHX use and postpartum hemorrhage prevention. The activity is provided in both Dari and Pashto and is accompanied by training on tablet use and focused counseling points around the content for each video topic. CHWs then show videos to community members at health post sessions or in clients' homes and provide counseling and facility referrals based on identified needs. A feasibility and acceptability assessment relayed promising results, but an effectiveness study is needed to determine whether this approach results in FP/RMNCH behavior change.

While our qualitative data reflect multiple, well-established barriers to completing four or more ANC visits or delivering at a facility, most adult male participants whose wives gave birth in the past two years did so in a facility. Further, adult male participants assigned high value to how they personally are regarded in their communities, so setting new norms around successfully accessing care and having healthy families could resonate with them. Thus, "positive deviants" (i.e., families in rural communities who successfully navigate logistical, financial, and security barriers to access FP/MNCH care and experience good outcomes) may be powerful motivators through audiovisual media. These families can first be identified through CHW reports and other community-based activities. They can then be interviewed, ideally through

videotaping, and their solutions to the barriers can be broadcast within similar communities through television, radio, and the video library. The choices and solutions of these families may compel others to adopt the same practices. We acknowledge that videotaping may come with security and social risks to a man or couple identified as the positive deviant. At the very least, interviews with the positive deviants should be conducted to describe their solutions, which can then be verbally presented in community dialogue sessions as case studies, or may be used without identifiers to create scripts for video library or mass media content that is "based on a true story."

Optimizing mobile phone potential as a health communications channel

We asked specifically about the feasibility of mobile phone-based programming in this assessment, largely because of wide coverage and access to mobile networks and use of mobile phones for FP/RMNCH SBC programming in other contexts. Mobile phone programming that allows clients to access messaging on demand and at their convenience, rather than "blast" messaging, and programs that allow clients to speak to a live operator are likely to be better received. However, advance marketing and directed promotions will be necessary for mobile phone SBC programming to reach target audiences, for several reasons. First, marketing strategies for mobile-based client-controlled FP/RMNCH activities should be directed at male heads of household and community leaders or key influencers, to permit female and youth access to the number or short code associated with the program. Similarly, this approach should be used to introduce a program requiring clients to register to receive calls to their numbers. This approach was recommended by both female and male youth and by male adults to address family concerns associated with unknown numbers and to reinforce the credibility of the information source. Specifically, promoting short codes specific to one segmented population but linking to the same platform menu for an interactive voice response (IVR) service may help moderate social barriers for women and youth accessing essential FP/RMNCH information.

Another reason advance marketing and directed promotions will be necessary is that current mobile phone-based health programs have not been widely promoted, even among subscribers of the mobile network operators who sponsor current programs. Most participants preferred "live" operator services, and among mobile network operators, MTN has a sponsored service, as does the MOPH in the public sector. However, few participants mentioned any prior use of mobile phone health programs, and the public-sector call-in center was not spontaneously mentioned in any qualitative interviews. By contrast, the Roshan 2-3-4 service, supported by Viamo, on which public service content is posted for on-demand access at no cost to subscribers, launched in October 2017. With no promotion outside of the televised launch ceremony and a small-scale distribution of some print material, the service had no more than 1,850 callers accessing the posted FP content monthly. In June 2018, Roshan promoted the 2-3-4 platform through digital advertisement and radio promotion targeting male and female audiences separately, with a resultant 25,460 callers listened to complete FP content messages that month. Neither the promotion efforts nor the call volume has been sustained, but this strongly suggests that the success of this model is contingent on platform promotion through multiple channels appropriately segmented to the target audiences. Both the Roshan and MTN services are accessible only through user-paid calls and require ongoing operational expenses for staffing and technology costs, especially for bidirectional models. The MOPH-operated call-in center has been suspended due to lack of space for a server, funding, and other issues.

Sustained mobile phone-based FP/RMNCH programming will need to consider similar public-private partnership approaches with the MOPH or become an entirely private venture with MOPH oversight for content accuracy. Lessons from other contexts also indicate that long-term program sustainability requires user fees, but there is flexibility in the fee and billing structure.[49] As mHealth interventions become more robust in Afghanistan, research is needed to better define the awareness of, factors influencing the use of,

and acceptable price points for both pre-recorded menu-based health services and live operator health services. Tailored FP/RMNCH mobile-based services for specific audiences, particularly basic RH and family health management information for youth in preparation for marriage, would likely be well-received if marketed widely and in a culturally appropriate manner.

Special Population Considerations

The prior recommendations can be applied to most groups included in this assessment, but a few segments of these populations merit special consideration and potentially innovative approaches. This assessment is among the first to purposively include IDPs, and we uncovered several barriers and differences in channel preferences that should be considered in programming for IDPs. First, media preferences may reflect portability based on displacement, with radio and mobile phones notable preferences among this population. Promotion efforts for radio and mobile phone SBC programs should consider IDP-targeted messages that emphasize the reliability of these channels despite displacement. Next, the security and social order of an established community is lost with displacement, resulting in a potential absence of key influencers and traditional community consensus groups for social norm guidance and health decisions. Displaced families may not know where to go, may have too few resources to access care, and may hold more firmly to norms that limit women's mobility and agency in an unfamiliar social setting. It is unclear whether changes in environment may make IDPs more receptive to social or gender norm change, but the high proportion of male IDPs who agreed that wife beating was acceptable in a variety of situations indicates that rapid social-norm assessments and responsive programming to reduce IPV should be a high priority. This programming could incorporate an approach that fosters team problem solving for basic needs, including health care, between spouses. Notably, IDPs also had higher levels of knowledge about certain content areas, like CHX, suggesting either movement to an area where select FP/RMNCH information channels are more readily accessible or the accessibility of specialized health programming within IDP communities through groups like the United Nations High Commissioner for Refugees. Further research and documentation of successful health programmatic approaches tailored to IDPs, with consideration of recency of displacement, are also needed to better delineate SBC approaches for this community.

For youth, particularly those advancing to secondary education or beyond, peers and Internet/social media were additional communication channels of interest. In qualitative interviews, youth mentioned that they often relied on peers (particularly relatives) they trusted and viewed as being more informed about FP/RMNCH for the bulk of their information. School-based youth, particularly those who originated from rural communities, also stated that they themselves were viewed as a preferred and knowledgeable channel for health information. This role appeared to result in concern about whether the information they accessed and in turn relayed was accurate. It also led to anxiety via stated concerns over being unable to access sensitive yet essential information, such as information about sexual intercourse. Having discrete FP/RMNCH information channels with programming marketed specifically to youth would likely be desirable to these groups, and mobile phones and Internet are ideal channels due to increasing accessibility and availability on demand. As Internet use is slowly expanding in Afghanistan, web searches were frequently mentioned by youth as sources of health information, but with the caveat that social media (particularly Facebook) was a common and potentially inaccurate source. In response, a potential programmatic approach may be a MOPH-curated social media account publicized through schools and popular mass media venues from 6 to 9 PM—the hours of highest youth audience engagement. Within its posts and home page, the site can encourage readers to serve as key informants by conveying the information to others in their social network who may not have Internet access—a process already described in qualitative data. A similar programmatic approach could be used for call-in centers with special "youth hours" when callers could speak anonymously with peer counselors (potentially health professions school students trained in FP/RMNCH and general health counseling and motivation).

For out-of-school youth, in addition to mobile phone programs, merging health programming with vocational training represents another opportunity for engagement. Linking FP/RMNCH information and counseling services with community-based livelihood programming, such as Farmer Field Schools, may provide an acceptable means of reaching young people with a comprehensive program to aid in the transition to adult responsibilities. Religious and community leaders could sanction and endorse such a merged health and vocational program, or could endorse a client-accessed phone information service, especially for female youth, as part of preparing for marriage and adulthood. This may lead to increased uptake in rural areas, as mullahs retain a forum for such endorsement (i.e., Friday mosque services) with frequent attendance by household decision makers.

Conclusions

Overall, the key recommendation from this report is the need for comprehensive programming that merges detailed FP/RMNCH information with approaches that address attitudes and normative perceptions and transforms them to promote efficacy to improve health practices. Our findings also show that people want interaction around sensitive and important topics and provides insight into channels that can conceivably convey this information in a reliable, private, and cost-effective manner in the Afghan context. Looking forward, if activities that incorporate these recommendations are implemented, developing indicators that assess FP/RMNCH information sources and exposure to community-level, mass media, and mobile-based interventions will be critical to refining these activities and determining levels of associated behavior change.

REFERENCES

1. GBD 2015 Maternal Mortality Collaborators. Global, regional, and national levels of maternal mortality, 1990-2015: a systematic analysis for the Global Burden of Disease Study 2015. Lancet. 2016;388(10053):1775-1812.
2. Akseer N, Salehi AS, Hossain SM, Mashal MT, Rasooly MH, Bhatti Z, Rizvi A, Bhutta ZA. Achieving maternal and child health gains in Afghanistan: a Countdown to 2015 country case study. Lancet Glob Health. 2016;4(6):e395-413.
3. Central Statistics Organization (CSO), Ministry of Public Health (MoPH), and ICF. 2017. Afghanistan Demographic and Health Survey 2015. Kabul, Afghanistan: Central Statistics Organization.
4. Bartlett L, LeFevre A, Zimmerman L, Saeedzai SA, Turkmani S, Zabih W, Tappis H, Becker S, Winch P, Koblinsky M, Rahmanzai AJ. Progress and inequities in maternal mortality in Afghanistan (RAMOS-II): a retrospective observational study. Lancet Glob Health. 2017;5(5):e545-e555.
5. CSO and UNICEF. Afghanistan Multiple Indicator Cluster Survey 2010-2011: Final Report. Kabul: CSO and UNICEF. 2012.
6. Mansoor GF, Hashemy P, Gohar F, Wood ME, Ayoubi SF, Todd CS . Midwifery retention and coverage and impact on service utilisation in Afghanistan. Midwifery. 2013;29(10):1088-94.
7. Afghan Public Health Institute (APHI/MoPH) [Afghanistan], Central Statistics Organization (CSO) [Afghanistan], ICF Macro, Indian Institute of Health Management Research (IIHMR) [India], & World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO) [Egypt]. Afghanistan mortality survey 2010. ICF Macro, Calverton, Maryland, US. 2011.
8. MoPH/UNICEF/AKU/SRTRO. National Nutrition Survey Afghanistan 2013. Kabul, 2013.
9. Higgins-Steele A, Yousufi K, Sultana S, Ali AS, Varkey S. Ending Preventable Child Deaths from Pneumonia and Diarrhoea in Afghanistan: An Analysis of Intervention Coverage Scenarios Using the Lives Saved Tool. J Trop Med. 2017;2017:3120854.
10. Naziri M, Higgins-Steele A, Anwari Z, Yousufi K, Fossand K, Amin SS, Hipgrave DB, Varkey S. Scaling up newborn care in Afghanistan: opportunities and challenges for the health sector. Health Policy Plan. 2018;33(2):271-282.
11. Belay, TA. Building on early gains in Afghanistan's health, nutrition, and population sector: challenges and options. Directions in development; human development. Washington, DC: World Bank, 2010.
12. United States Agency for International Development (USAID). Connecting to Opportunity: A Survey of Afghan Women's Access to Mobile Technology. USAID, Washington, DC, USA. 2013.
13. Asia Foundation. A Survey of the Afghan People: Afghanistan in 2017. Asia Foundation, 2017, San Francisco, California, USA.
14. Haider S, Todd C, Ahmadzai M, Rahimi S, Azfar P, Morris JL, Miller S. Childbearing and contraceptive decision making amongst Afghan men and women: a qualitative analysis. Health Care Women Int. 2009;30(10):935-53.
15. van Egmond K, Naeem AJ, Verstraelen H, Bosmans M, Claeys P, Temmerman M. Reproductive health in Afghanistan: results of a knowledge, attitudes and practices survey among Afghan women in Kabul. Disasters. 2004;28(3):269-82.
16. Family Health Alliance. Male Health Provider Family Planning / Reproductive Health Training Program in Afghanistan. Available at: http://familyhealthalliance.org/programs/male-training-afghanistan/. Accessed December 9, 2018.
17. Newbrander W, Natiq K, Shahim S, Hamid N, Skena NB. Barriers to appropriate care for mothers and infants during the perinatal period in rural Afghanistan: a qualitative assessment. Glob Public Health. 2014;9 Suppl 1:S93-109.
18. Huber D, Saeedi N, Samadi AK. Achieving success with family planning in rural Afghanistan. Bull World Health Organ. 2010;88(3):227-31.
19. Altai Consulting. Afghan Media in 2010: Synthesis Report. Altai Consulting, Kabul, Afghanistan. 2010

20. United Nations Common Humanitarian Fund. Afghanistan: CHF Annual Report 2017. Kabul, 2018. Available at: http://www.unocha.org/sites/unocha/files/Afghanistan%20CHF%20-%20Annual%20Report%202017.pdf. Accessed December 9, 2018.
21. Nic Carthaigh N, De Gryse B, Esmati AS, Nizar B, Van Overloop C, Fricke R, Bseiso J, Baker C, Decroo T, Philips M. Patients struggle to access effective health care due to ongoing violence, distance, costs and health service performance in Afghanistan. Int Health. 2015;7(3):169-75.
22. Samuel Hall Consulting. "Afghanistan's Future in Transition: A Participatory Assessment of the Afghan Youth", research commissioned by DMoYA, UNDP, UNFPA, and UNICEF; Kabul, 2013.
23. Najafizada SA, Labonté R, Bourgeault IL. Community health workers of Afghanistan: a qualitative study of a national program. Confl Health. 2014;8:26.
24. Kim C, Saeed KM, Salehi AS, Zeng W. An equity analysis of utilization of health services in Afghanistan using a national household survey. BMC Public Health. 2016;16(1):1226.
25. Akseer N, Bhatti Z, Rizvi A, Salehi AS, Mashal T, Bhutta ZA. Coverage and inequalities in maternal and child health interventions in Afghanistan. BMC Public Health. 2016;16 Suppl 2:797.
26. Samar S, Aqil A, Vogel J, Wentzel L, Haqmal S, Matsunaga E, Vuolo E, Abaszadeh N. Towards gender equality in health in Afghanistan. Glob Public Health. 2014;9 Suppl 1:S76-92.
27. Smith DJ. Decisions, Desires and Diversity: Marriage Practices in Afghanistan. Kabul: Afghanistan Research & Evaluation Unit. 2009.
28. Land Info/ Country of Origin Information Center. Afghanistan: Blood feuds, traditional law (pashtunwali) and traditional conflict resolution. Oslo, Norway, 2012. Available at: https://www.ecoi.net/en/file/local/1104068/1788_1327313532_1940-1.pdf. Accessed December 9, 2018.
29. Panter-Brick C, Eggerman M, Gonzalez V, Safdar S. Violence, suffering, and mental health in Afghanistan: a school-based survey. Lancet. 2009;374(9692):807-16.
30. Edward A, Branchini C, Aitken I, Roach M, Osei-Bonsu K, Arwal SH. Toward universal coverage in Afghanistan: A multi-stakeholder assessment of capacity investments in the community health worker system. Soc Sci Med. 2015;145:173-83.
31. Health Communication Capacity Collaborative/USAID. Service Communication Implementation Kit: Integrating SBCC Into Service Delivery Programs. Johns Hopkins University, Baltimore, Maryland, US, 2016. Available at: https://sbccimplementationkits.org/service-communication/wp-content/uploads/sites/13/2017/01/ServiceCom-I-Kit-Templates.pdf. Accessed December 9, 2018.
32. Arnold R, van Teijlingen E, Ryan K, Holloway I. Understanding Afghan healthcare providers: a qualitative study of the culture of care in a Kabul maternity hospital. BJOG. 2015;122(2):260-7.
33. Howard N, Woodward A, Patel D, Shafi A, Oddy L, ter Veen A, Atta N, Sondorp E, Roberts B. Perspectives on reproductive healthcare delivered through a basic package of health services in Afghanistan: a qualitative study. BMC Health Serv Res. 2014;14:359.
34. Tawfik Y, Rahimzai M, Ahmadzai M, Clark PA, Kamgang E. Integrating family planning into postpartum care through modern quality improvement: experience from Afghanistan. Glob Health Sci Pract. 2014;2(2):226-33.
35. Miyake S, Speakman EM, Currie S, Howard N. Community midwifery initiatives in fragile and conflict-affected countries: a scoping review of approaches from recruitment to retention. Health Policy Plan. 2017;32(1):21-33.
36. Qarani WM, Jan R, Saeed KMI, Khymani L. We need higher education: Voice of nursing administration from Kabul, Afghanistan. Nurs Open. 2018;5(3):317-322.
37. Khoja S, Khan MA, Husyin N, Scott R, Yousafzai AW, Durrani H, Mohbatali F, Khan D. Improving Mental Health Care for Young Adults in Badakshan Province of Afghanistan Using eHealth. Stud Health Technol Inform. 2015;209:46-50.
38. Shafiqullah H, Morita A, Nakamura K, Seino K. The family planning conundrum in Afghanistan. Health Promot Int. 2018;33(2):311-317.

39. Edmond KM, Yousufi K, Anwari Z, Sadat SM, Staniczai SM, Higgins-Steele A, Bellows AL, Smith ER. Can community health worker home visiting improve care-seeking and maternal and newborn care practices in fragile states such as Afghanistan? A population-based intervention study. BMC Med. 2018;16(1):106.
40. Namey E, Guest G, McKenna K, Chen M. Evaluating Bang for the Buck: A Cost-Effectiveness Comparison Between Individual Interviews and Focus Groups Based on Thematic Saturation Levels. Am J Evaluation. 2016; 37(3): 425-440.
41. MoPH, Indian Institute of Health Management Research, & Johns Hopkins Bloomberg School of Public Health. Afghanistan Health Survey 2012. MoPH. Kabul. 2013.
42. Sadaat SM. InAsia: Weekly Insights and Analysis. What Factors Drive Child Marriage in Afghanistan? Available at: https://asiafoundation.org/2017/03/22/factors-drive-child-marriage-afghanistan/. Accessed December 9, 2018.
43. Echavez CR, Mosawi SM, Pilongo LW. The Other Side of Gender Inequality: Men and Masculinities in Afghanistan. Kabul, Afghanistan; Afghanistan Research and Evaluation Unit (AREU), 2016.
44. AREU. AREU Issues Paper: Women's Rights, Gender Equality, and Transition: Securing gains, moving forward. Kabul, Afghanistan; AREU, 2013.
45. The White Ribbon Alliance (WRA). Self Care: A Cost Effective Solution for Maternal, Newborn & Child Health for All. A WRA Policy Brief. WRA, Washington, DC, USA, 2016.
46. Waverly R, Koniz-Booher P, Rogers B, Moreaux M. SBCC in the Sahel: A Landscape Assessment of Nutrition and Hygiene Social and Behavior Change Communication in Niger and Burkina Faso. 2014; Arlington, VA: USAID/Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) Project.
47. Wood ME, Mansoor GF, Hashemy P, Namey E, Gohar F, Ayoubi SF, Todd CS. Factors influencing the retention of midwives in the public sector in Afghanistan: a qualitative assessment of midwives in eight provinces. Midwifery. 2013;29(10):1137-44.
48. The World Bank. Press Release: Ministry of Finance and the World Bank Sign $691 Million Financing to Improve Afghanistan's Economy and Healthcare. Available at: http://www.worldbank.org/en/news/press-release/2018/04/10/ministry-of-finance-world-bank-sign-usd691-million-grant-financing-package. Accessed December 9, 2018.
49. Maternal Child Survival Program, USAID, Johnson and Johnson, United Nations Fund, Baby Center, MAMA. Lessons from Country Programs Implementing the Mobile Alliance for Maternal Action Programs in Bangladesh, South Africa, India, and Nigeria, 2010–2016. MCSP, Washington D.C., 2017. Available at: http://bit.ly/MAMAReport. Accessed December 9, 2018.

Annex I:
ETHICAL APPROVALS

Protection of Human Subjects Committee

INITIAL EXPEDITED REVIEW APPROVAL NOTICE

DATE:	March 8, 2016
TO:	Catherine Todd
PROJECT #:	844213
TITLE:	Formative Assessment of Current Knowledge and Attitudes and Preferred Media for Messaging for Reproductive Health Information among Youth and Men in Afghanistan
APPROVAL DATE:	March 8, 2016
EXPIRATION DATE:	March 3, 2017
RISK LEVEL:	Minimal Risk
EXPEDITED RESEARCH CATEGORY:	7

Thank you for submitting *Formative Assessment of Current Knowledge and Attitudes and Preferred Media for Messaging for Reproductive Health Information among Youth and Men in Afghanistan* for review by the Protection of Human Subjects Committee (PHSC).

We are pleased to inform you this research study has been approved through expedited review by the PHSC. This approval is effective from March 8, 2016 until March 3, 2017 and is based on an appropriate risk/benefit ratio and a project design in which the risks have been minimized.

All research activities must be conducted in accordance with this approved submission. It is your responsibility to fulfill the following requirements of approval:

1. All key personnel [Principal Investigator, Project Leader, and Co-Investigator(s)] listed in the Protocol must be kept informed of the status of the project.
2. Any changes or revisions to a previously approved protocol, or any research related materials must be submitted to the PHSC for re-review and approval prior to implementation.

Generated on IRBNet

3. Any unanticipated problems, adverse events, protocol violations, social harm, or any new information becoming available which could change the risk/benefit ratio must be reported to the PHSC according to FHI 360 policy.
4. Please remember informed consent is a process beginning with a description of the project and confirmation that the participant understands and voluntarily agrees to their role in this research. Only the approved informed consent process/forms are to be used in the enrollment of participants. Documentation of consent, such as forms signed by subjects and/or witnesses, should be retained in the researcher's file and be readily available for review by the PHSC.
5. Research studies must undergo continuing review at least annually (365 days). It is the researchers' responsibility to ensure continuing review occurs prior to the end of the approval period. Therefore, a complete Project Status Report needs to be submitted at least 15-days prior to the expiration date. If continuing approval is not obtained prior to March 3, 2017, all research activities involving human subjects must stop. These activities include enrollment of new participants, participant intervention or interaction, and obtaining or analyzing identifiable private information. Performing research activities beyond the expiration date results in non-compliance of federal regulations.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within FHI 360 records.

FHI 360 HEADQUARTERS 359 Blackwell Street, Suite 200 | Durham, NC 27701 USA
T 1.919.544.7040 | **F** 1.919.544.7261 | **www.fhi360.org**

Generated on IRBNet

Islamic Republic of Afghanistan
Ministry of Public Health
Afghanistan National Public Health Institute
Institutional Review Board

جمهوری اسلامی افغانستان
وزارت صحت عامه
انستیتوت ملی صحت عامه افغانستان

د افغانستان اسلامی جمهوریت
د عامی روغتیا وزارت
د افغانستان د عامې روغتیا ملي انسټیټوټ

Date: 23/May/2016

No. 355310

To: **Catherine Todd, M.D., MP**
Technical Team Lead

Subject: Approval for proposal entitled, **"Formative Assessment of Current Knowledge and Attitudes and Preferred Media for Messaging for Reproductive Health Information among Youth and Men in Afghanistan".**

Dear Todd,

Institutional Review Board, Ministry of Public Health has examined and reviewed your proposal entitled, **"Formative Assessment of Current Knowledge and Attitudes and Preferred Media for Messaging for Reproductive Health Information among Youth and Men in Afghanistan".**

We are pleased to note satisfactory response therefore, your study is approved. However, we reserve the rights to monitor and audit your study and any violation of ethical norms during the course of study shall lead to withdrawal of given approval.

The duration of approval for a study to begin the research project is valid for six months and the exact date of research project implementation (start and end) should be informed to IRB secretary.

You are bound to share the result of your study with MoPH prior any dissemination plan.

Sincerely,

Bashir Noormal *MD, MPH*
Director General
Afghanistan National Public Health Institute (ANPHI) &
Chairman, Institutional Review Board (IRB)
Ministry of Public Health

Telephone No.: +93 (0) 20 29 22 435
Email Address: anphi@moph.gov.af
Website: www.anphi.moph.gov.af
Postal Address: 3rd Floor of Main Building of Ministry of Public Health, Masoud Circle, Wazir Akbar Khan, Kabul-Afghanistan

نمبر تیلفون: +93 (0) 20 29 22 435
آدرس الکترونیکی: anphi@moph.gov.af
صفحه انترنتی: www.anphi.moph.gov.af
آدرس پستی: منزل سوم تعمیر اصلی وزارت صحت عامه،
چهارراهی مسعود، وزیر اکبر خان مینه، کابل-افغانستان

Annex 2:
QUAN INSTRUMENTS

IDP YOUTH MNCH COMMUNICATIONS SURVEY
QUANTITATIVE COMPONENT

Introduction

Thank you for agreeing to participate in this survey. I will be asking you questions about various issues regarding health and communication, both generally and as they pertain to you and other people your age. This conversation will last about 30 minutes and you can ask for a break at any time if you need one. Also, if any question is unclear or you would like to discuss it prior to answering, please ask me. You may also decline to answer any question you do not wish to answer. All of your answers are private and we will not be recording your name or other information that can identify you personally. Are you ready to begin the questionnaire?

Respondent agrees to be interviewed. ☐ Yes (go to 001) ☐ No (STOP)

For Field Manager Completion			
001	Survey code		
002	Interviewer code		
003	Supervisor code		
004	Have data been cleaned and are they complete?	**Supervisor signature:**	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
100	Source organization	1. GIHS 2. Secondary school 3. Other (specify): _____	_____	
101	City/district of interview	1. Kabul 2. Jalalabad 3. Taloquan 4. Kama 5. Khiwa 6. Baharak 7. Khwaja Bahauddin	_____	
102	If city, district number	District number	_____	
103	Province of interview	1. Kabul 2. Nangarhar 3. Takhar	_____	
104	Date of interview	Day/Month/Year using Gregorian calendar	_____ Day/ _____ Month/ _____ Year	
105	Start time of interview (hours written in 24 hour clock, for example 8 p.m. = 20:00 hours)	Hours written in 24 hour clock, for example 8 p.m. = 20:00 hours	_____ hrs: _____ min	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
We are asking for you to please provide a telephone number so we can complete quality assurance measures for this study; we may call you to verify that you completed the interview but we will not ask about any of your answers or any identifying information from you.				
106	Telephone number for quality assurance	Enter telephone number	_____	
107	Language of interview	1. Dari 2. Pashto 9. Other (specify): _____	_____	If Other, thank participant and STOP interview.
Demographic Data				
200	How old (number of years) are you right now? Please make your best guess.	Number of years (99=don't know year)	_____	
201	Were you born in Afghanistan?	0. No 1. Yes	_____	If 0, go to 203; if 1, go to 204
202	In what country were you born?	1. Pakistan 2. Iran 3. Tajikistan 4. India 5. Arab Emirates 6. Other (specify): _____	_____	Go to 205.
203	In what province were you born?	1. Badghis 2. Baghlan 3. Badakhshan 4. Balkh 5. Bamiyan 6. Daikundi 7. Farah 8. Faryab 9. Ghazni 10. Ghor 11. Helmand 12. Herat 13. Jawzjan 14. Kabul 15. Kandahar 16. Kapisa 17. Khost 18. Kunar 19. Kunduz 20. Laghman 21. Logar 22. Nangahar 23. Nimroz 24. Nuristan 25. Paktia 26. Paktika 27. Panjshir 28. Parwan 29. Samangan 30. Saripul 31. Takhar 32. Uruzgan 33. Wardak 34. Zabul	_____	Go to 205.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
204	Is your home (where your family was living before coming to this place) in the same province where you were born?	0. No 1. Yes	_____	If 0, go to 206; if 1, go to 207.
205	If no, in what province is your current home located?	1. Badghis 2. Baghlan 3. Badakhshan 4. Balkh 5. Bamiyan 6. Daikundi 7. Farah 8. Faryab 9. Ghazni 10. Ghor 11. Helmand 12. Herat 13. Jawzjan 14. Kabul 15. Kandahar 16. Kapisa 17. Khost 18. Kunar 19. Kunduz 20. Laghman 21. Logar 22. Nangahar 23. Nimroz 24. Nuristan 25. Paktia 26. Paktika 27. Panjshir 28. Parwan 29. Samangan 30. Saripul 31. Takhar 32. Uruzgan 33. Wardak 34. Zabul	_____	
206.	Before coming to this place, what was the main source of income for your family?	1. Agriculture 2. Rearing animals 3. Service/salaried 4. Business/trading 5. Remittance 6. Seasonal Worker 7. Labor (daily wages) 8. Other (specify): _____	_____	
207.	In your family home (where you lived before coming to this place), what is the main material used for the floor?	1. Wood 2. Mud 3. Tile/brick 4. Concrete 5. Other (specify): _____	_____	
208	What would you estimate is the current monthly income level of your family?	Number in Afs. Put in 0's before first number to fill all spaces. If unknown, insert 999999 in all spaces.	_____ Afs	
The next question will ask about common things people may have in their homes. We are asking this question so we are able to compare answers between similar and different people and this is one way of understanding important differences between households when we consider peoples' different health needs.				

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
209 a-m.	Does your family (with whom you are living) own any of the following? Please, include only those that work, not broken. [INTERVIEWER: READ EACH ITEM OUT LOUD. MARK Yes (1) or No (2) for each item.]	a. Refrigerator b. Stove/gas cooker c. Radio d. Television e. DVD player f. Satellite phone g. Mobile phone without internet h. Mobile "Smart" phone with internet i. Bicycle j. Motorcycle k. Car m. None of the above	a. _____ b. _____ c. _____ d. _____ e. _____ f. _____ g. _____ h. _____ i. _____ j. _____ k. _____ m. _____	
210	In your family home (where you lived before coming to this place), what is the main source of drinking water?	1. Piped water into dwelling 2. Piped water to yard/plot 3. Public tap/standpipe 4. Tube well or borehole 5. Dug well 6. Protected well 7. Unprotected well 8. Protected spring 9. Unprotected spring 10. Rainwater 11. Tanker truck 12. Cart with small tank/drum 13. Surface water (river/dam/lake/ pond/stream/canal/ irrigation channel) 14. Bottled water 15. Other	_____	
211	Have you ever attended school?	0. No 1. Yes	_____	If 0, go to 216.
212	Are you currently a student?	0. No 1. Yes	_____	
213	What is the highest level of school you attended: primary, secondary, or higher?	1. Primary 2. Secondary 3. Higher 4. Vocational 5. Madrassa	_____	
214	What is the highest grade you completed?	Enter number with 0 first if the number is a single digit. If completed less than grade one, record '00'.	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
215	Now could you please read this sentence to me? [Show participant the card] [If participant cannot read the whole sentence:] Can you read any part of the sentence to me?	1. Cannot read at all 2. Can read part of the sentence 3. Can read all of the sentence 4. Blind/visually impaired	_____	
216	To which ethnic group (milat) do you belong?	1. Pashtun 2. Tajik 3. Hazara 4. Uzbek 5. Turkmen 6. Nuristani 7. Baluch 8. Pashai 9. Other (specify): _____	_____	
Media Exposure and Preferences				
300	[Check response to 215 – do not ask if cannot read sentence] How often do you read a newspaper or magazine?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If 4, go to 304.
301	For what type of information do you read a newspaper or magazine? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. News/ current events 2. Political/religious commentary 3. Sports 4. Entertainment 5. Job advertisements 6. Other (specify): _____	_____	
302	Have you received health information from a newspaper or magazine in the last 30 days?	0. No 1. Yes	_____	
303	What was this information regarding? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/hygiene 5. Nutrition 6. High blood pressure 7. Smoking cigarettes 8. Other (specify): _____	_____ _____ _____ _____ _____ _____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
304	How often do you listen to the radio?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If not at all, go to 310.
305	At what times do you usually listen to the radio?	1. 0:00 – < 6:00 2. 6:00 – < 9:00 3. 9:00 – < 12:00 4. 12:00 – < 15:00 5. 15:00 – < 18:00 6. 18:00 – <21:00 7. 21:00 – < 24:00	_____ _____ _____	
306	For what type of programming do you listen to the radio? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. International news 2. National news 3. Local news 4. Music 5. Religious 6. Sports 7. Culture 8. Political debates 9. Entertainment 10. Health 11. Social 12. Drama 13. Other (specify): _____	_____ _____ _____ _____ _____	
307	Have you received health information from the radio in the last 30 days?	0. No 1. Yes	_____	If no, go to 310.
308	What was this information regarding?	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/hygiene 5. Nutrition 6. High blood pressure 7. Smoking cigarettes 8. Other (specify): _____	_____ _____ _____	
309	What are the two radio stations you listen to most frequently?	[Write out station names]	_____ _____	
310	How often do you watch television?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If 4, go to 315

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
311	At what times do you usually watch television?	1. 0:00 – < 6:00 2. 6:00 – < 9:00 3. 9:00 – < 12:00 4. 12:00 – < 15:00 5. 15:00 – < 18:00 6. 18:00 – <21:00 7. 21:00 – < 24:00	_____ _____ _____	
312	For what type of programming do you listen to the radio? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. International news 2. National news 3. Local news 4. Music 5. Religious 6. Sports 7. Culture 8. Political debates 9. Entertainment 10. Health 11. Social 12. Drama 13. Other (specify): _____	_____ _____ _____ _____ _____	
313	Have you received health information from television in the last 30 days?	0. No 1. Yes	_____	If 0, go to 315.
314	What was this information regarding?	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/hygiene 5. Nutrition 6. High blood pressure 7. Smoking cigarettes 8. Other (specify): _____	_____ _____ _____	
315	What are the two television channels you watch most frequently?	[Write out station names]	_____ _____ _____	
316	Do you own a mobile phone for your own personal use?	0. No 1. Yes 88. No answer	_____	If 1 or 88, go to 318.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
317.	Do you know someone (i.e. friend or neighbor) who owns a mobile phone you could use if you needed to do so?	0. No 1. Yes 88. No answer 99. Don't know	_____	
318	Have you ever used Internet on any of these devices: computer, smart phone, and/or tablet?	0. No 1. Yes 88. No answer	_____	If 0 or 88, go to 324.
319	Have you ever accessed the Internet?	0. No 1. Yes 88. No answer	_____	If 0 or 88, go to 324.
320	How often do you access the Internet?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If 4, go to 324.
321	What type of information do you get from the Internet? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Email/social media 2. Current events 3. Political/religious commentary 4. Sports 5. Entertainment 6. Job advertisements 7. Other (specify): _____	_____ _____ _____	
322	Have you received health information from the Internet in the last 30 days?	0. No 1. Yes	_____	If 0, go to 324.
323	What was this information regarding?	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/hygiene 5. Nutrition 6. High blood pressure 7. Smoking cigarettes 8. Other (specify): _____	_____ _____ _____	
324	Have you received care from a medical provider in the last 6 months?	0. No 1. Yes	_____	If 0, go to 327.
325	Did you receive any counseling or instruction on how to improve/maintain your health?	0. No 1. Yes	_____	If 0, go to 327.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
326	On what topic(s) did you receive information? INTERVIEWER: Do not read list; circle all areas the participant mentions spontaneously. Multiple answers are acceptable.	1. Health maintenance (exercise/ nutrition) 2. Smoking cessation 3. Accident prevention 4. Stress reduction 5. Depression or other mental health issues 6. Family planning 7. Women's health 8. Child health 9. Can't remember 10. Other (specify): _____	_____ _____ _____	
327	Where do you generally get information about health? (INTERVIEWER: Do not read list; circle all areas the participant mentions spontaneously. Multiple answers are acceptable.)	1. Family member 2. Friend 3. Religious leader/mullah 4. Village leader 5. Doctor/nurse/midwife 6. Community health worker 7. Television 8. Radio 9. Internet 10. Newspaper/books 11. Telephone hotline/program 12. No answer	_____ _____ _____	
328	In the last 12 months, have you received any information about health reasons to delay marriage and/or childbearing?	0. No 1. Yes 88. No answer	_____	If 0 or 88, go to 329. If 1, go to table on next page (331).
329	In the last 12 months, have you received any information about child health, including advice about breastfeeding and other child feeding?	0. No 1. Yes 88. No answer	_____	If 0 or 88, go to 330. If 1, go to table on next page (334).
330	In the last 12 months, have you received any information about birth spacing or ways to time pregnancy?	0. No 1. Yes 88. No answer	_____	If 1, go to table on next page (337). If 0 or 88, go to 340.

In the table below, please ask the question in each column and enter the number for the source reported by the participant. The participant may provide the answer for more than one question at one time. If so, please mark the answer without re-asking the question. Please do NOT read the entire list of sources but only enter the number in the question response box for the one(s) stated by the participant.

Response Choices	331. Where did you receive information about health reasons to delay marriage and/ or childbearing? (multiple answers allowed)	332. Which source was most convenient? (One answer only)	333. Which source was most informative/ accurate? (One answer only)	334. Where did you receive information on breastfeeding or child health?	335. Which source was most convenient? (One answer only)	336. Which source was most informative/ accurate? (One answer only)	337. Where did you receive information about birth spacing or avoiding pregnancy?	338. Which source was most convenient? (One answer only)	339. Which source was most informative/ accurate? (One answer only)
0. Did not receive information									
1. Mother									
2. Father									
3. Brother/ sister									
4. Other family member									
5. Friend									
6. Religious leader/ mullah									
7. Village leader									
8. Teacher									
9. Doctor/ nurse/ midwife									

Response Choices	331. Where did you receive information about health reasons to delay marriage and/ or childbearing? (multiple answers allowed)	332. Which source was most convenient? (One answer only)	333. Which source was most informative/ accurate? (One answer only)	334. Where did you receive information on breastfeeding or child health?	335. Which source was most convenient? (One answer only)	336. Which source was most informative/ accurate? (One answer only)	337. Where did you receive information about birth spacing or avoiding pregnancy?	338. Which source was most convenient? (One answer only)	339. Which source was most informative/ accurate? (One answer only)
10. Community health worker									
11. Television									
12. Radio									
13. Internet									
14. Newspaper/ books									
15. Telephone hotline/ program									
88. No answer									
99. Don't know									

STUDY STAFF: After 333, go to 329.
After 336, go to 330.
After 339, go to 340.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
340	Do you feel you need more information about health or how to maintain your health?	0. No 1. Yes 88. No answer 99. Don't know	_____	If 0 or 88, go to 342.
341	For what health areas would you want further information?	1. Health maintenance (exercise/ nutrition) 2. Smoking cessation 3. Accident prevention 4. Stress reduction 5. Depression or other mental health issues 6. Care during pregnancy before birth 7. Care during the birth process 8. Best care for a healthy newborn 9. Instructions on breastfeeding and best infant feeding practices 10. Information about nutrition and feeding your family 11. Information about birth spacing methods 12. Other (specify): _____	_____ _____ _____	
342	If additional information about birth spacing or protecting the health of mothers and children were available, what are the best ways to reach you? Please list the best way first, followed by the second, etc. (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. Multiple answers acceptable.)	1. Discussion with healthcare provider 2. Home visit with a community-based health worker 3. Printed information 4. Television 5. Radio 6. Send information by mobile phone in voice call 7. Telephone hotline 8. Other (specify): _____ 9. No answer	_____ _____ _____	
Now, I would like to ask you some questions about women's and children's health. Please say whether you agree or disagree with the following statements.				
400	A pregnant woman should go for regular antenatal check-ups even if she is not sick. What do you think of that statement?	1. Disagree 2. Agree 8. No answer 9. Don't know	_____	

For interviewer completion only				
#	**Question**	**Response Choices**	**Entry**	**Skip Pattern**
401	Women should have at least 4 antenatal care visits during pregnancy.	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
402	In your opinion, what are some serious health problems that can occur during pregnancy that could endanger the life of a pregnant woman? I am referring to the time of pregnancy, not to the time of birth. (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Bleeding 2. Severe Headache 3. Blurred Vision 4. Convulsions 5. Swollen Hands/Face 6. Fever 7. Loss of Consciousness 8. Difficulty Breathing 9. Severe Weakness 10. Severe Abdominal Pain 11. Reduced Fetal Movement 12. Water Breaks without Labor 13. Other (specify): _____ 14. None 15. Don't know 16. No answer	_____ _____ _____	
403	In your opinion, could a woman die from any of these problems?	0. No 1. Yes 88. No answer 99. Don't know	_____	
404	Are women who become pregnant before age 18 at greater, the same, or lower risk of having complications with the pregnancy as women aged 18 to 34?	1. Greater risk 2. The same risk 3. Lower risk 88. No answer 99. Don't know	_____	
405	What could a woman do to reduce the risk of health problems occurring during pregnancy? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Go for regular antenatal health checkups to a midwife or doctor 2. Take traditional medicine 3. Avoid inappropriate foods 4. Consult the religious leader/ mullah 5. Consult a dayee 6. Consult her mother-in-law/ mother 7. Other (specify): _____ 8. Nothing 88. No answer 99. Don't know	_____ _____ _____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
406	What conditions is a woman aged less than 18 years at the time of delivery at greater risk for? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Pre-eclampsia/eclampsia 2. Severe headache 3. Blurred vision 4. Convulsions 5. Swollen hands/face 6. Baby cannot pass through the birth canal 7. Preterm labor/delivery 8. No answer 9. Don't know	_____ _____ _____	
407	In your opinion, where is the best place for a woman to give birth? (INTERVIEWER: Only 1 answer is acceptable here.)	1. At a health facility 2. At home 3. Other 88. No answer 99. Don't know	_____	
408	For what reasons do you think that is the best place for a woman to deliver a baby? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Less expensive 2. Safer 3. Better care 4. Easy to access 5. Privacy 6. Tradition 7. Other (specify): _____ 88. No answer 99. Don't know	_____ _____ _____	
409	In your opinion, what are some serious health problems that can occur during labor and childbirth that could endanger the life of a pregnant woman? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Severe Bleeding 2. Convulsions 3. High Fever 4. Loss of Consciousness 5. Labor Lasting > 12 Hours 6. Position of the baby is "wrong" 7. Placenta Not Delivered 30 Minutes After Baby 8. Other (specify): _____ 9. None 88. No answer 99. Don't know	_____ _____ _____	
410	In your opinion, could a woman die from any of these problems?	0. No 1. Yes 88. No answer 99. Don't know	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
411	In your opinion, what are some of the things a woman and her family can do to prepare for birth? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Go to a health facility 2. Move temporarily to stay closer to a facility 3. Identify Mode of Transport to health facility 4. Save Money 5. Identify Blood Donor 6. Identify Skilled Provider 7. Other (specify): _____ 8. Nothing 88. No answer 99. Don't know	_____ _____ _____	
412	In your opinion, what is the best way to care for the umbilical cord after cutting?	1. Keep it dry 2. Use chlorhexidine to clean daily for 1 week 3. Apply something else to the remaining cord 4. Other (specify): _____ 88. No answer 99. Don't know	_____	
413	In your opinion, what is/are the best way(s) to maintain the baby's body temperature after birth? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Put hat on baby's head 2. Keep baby well wrapped in swaddling 3. Keep baby wrapped on the mother's chest 4. Delay bathing the baby 5. Make sure the room is warm 6. Other (specify): _____ 88. No answer 99. Don't know	_____ _____ _____	
414	How long after birth should a newborn start breastfeeding?	1. Within one hour 2. Within several hours 3. Within one day 4. Within several days 5. When the white milk comes in 88. No answer 99. Don't know	_____	
415	Which is better for an infant younger than 6 months, breast milk alone or a combination of breast milk and infant formula?	1. Breast milk alone 2. Combination of breast milk and infant formula 88. No answer 99. Don't know	_____	

For interviewer completion only				
#	**Question**	**Response Choices**	**Entry**	**Skip Pattern**
416	Until what month of age should a mother do the following things: Give her infant **ONLY** breast milk and **NO** other foods, water or infant formula?	_____ months 88. No answer 99. Don't know (Enter numbers and place 0 before the number if the response is a single number)	_____ _____ _____	
417	Continue breastfeeding even if providing complementary food?	_____ months 88. No answer 99. Don't know (Enter numbers and place 0 before the number if the response is a single number)	_____ _____ _____	
We will now ask you some questions about family planning. Please let me know if you need to take a break before we start the new set of questions. You are doing very well.				
500	Now I would like to ask you about a woman's risk of pregnancy. From one menstrual period to the next, have you heard if there are certain days when a woman is more likely to become pregnant when she has sexual relations?	0. No 1. Yes 88. No answer 99. Don't know	_____	If 0, 88, or 99, go to 502.
501	Is this time just before her period begins, during her period, right after her period has ended, or halfway between two periods?	1. Just before her period 2. During her period 3. Right after her period has ended 4. Halfway between two periods 88. No answer 99. Don't know	_____	
502	Have you ever heard of ways or methods that a couple can use to delay or avoid a pregnancy?	0. No 1. Yes 88. No answer	_____	If 0 or 88, go to 504.

For interviewer completion only				
#	**Question**	**Response Choices**	**Entry**	**Skip Pattern**
503	Which ways or methods have you heard of? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. IUD/ loop 2. Condoms 3. Oral contraceptives 4. Injectable contraceptives 5. Implant 6. Female sterilization 7. Male sterilization 8. Rhythm method/standard days 9. Withdrawal 10. Lactational amenorrhea 11. Emergency contraception	_____ _____ _____	
504	For how many months after a baby is born will exclusive breastfeeding (meaning breast milk only is given to the baby, no solid food or other liquids) be effective for preventing pregnancy?	_____ months 88. No answer 99. Don't know	_____	
Please indicate whether you agree with the following statements regarding family planning:				
505	Withdrawal (*al azl*) is a highly effective method for preventing pregnancy	1. Disagree 2. Agree 99. Don't know	_____	
506	Young women should not use family planning methods because it may create problems getting pregnant later	1. Disagree 2. Agree 99. Don't know	_____	
507	The IUD or loop can prevent pregnancy for up to 10 years.	1. Disagree 2. Agree 99. Don't know	_____	
508	Irregular periods or bleeding between periods while using the injection or implant will usually resolve on its own.	1. Disagree 2. Agree 99. Don't know	_____	
Attitudes, Care Utilization, and Decision-making				
600	Have you been to a health facility for care for yourself in the last three months?	0. No 1. Yes 88. No answer	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
601	When you have a question about a health issue, what source do you usually consult for information? Please list the sources in the order of you would go to first, then second, etc.	1. Mother 2. Father 3. Brother/sister 4. Other family member 5. Friend 6. Religious leader 7. Internet 8. Book/magazine 9. Doctor/midwife 10. Community health worker 11. Hotline/Call center 12. Other (specify): _____ 13. No one 88. No answer	_____ _____ _____ _____ _____ _____	
602	When you have a question about reproductive health issues, what source do you usually consult for information? Please list the sources in the order of you would go to first, then second, etc.	1. Mother 2. Father 3. Brother/sister 4. Other family member 5. Friend 6. Religious leader 7. Internet 8. Book/magazine 9. Doctor/midwife 10. Community health worker 11. Hotline/Call center 12. Other (specify): _____ 13. No one 88. No answer	_____ _____ _____ _____ _____ _____	
603	If there were a free mobile phone based information project for reproductive health, how likely would you be to use it?	1. Very likely 2. Somewhat likely 3. Neither likely nor unlikely 4. Somewhat unlikely 5. Very unlikely/wouldn't use	_____	
604	If you used this mobile phone program for advice on family planning and general health, would you prefer to hear a recorded message or speak to a live person?	1. Hear a recorded message 2. Speak to a live person 99. Don't know	_____	

For interviewer completion only				
#	**Question**	**Response Choices**	**Entry**	**Skip Pattern**
I will now read you some statements about family decision-making that involve female members of your family. We are asking these questions to better understand what health information men provide to their wives and how much couples talk about health issues and decisions. These questions may be sensitive and you are welcome to ask me about why these questions are here. Please remember you may decline to answer a question at any time. If you agree, can we proceed? (If agrees, then proceed with next statement).. Please tell me if you agree or disagree with each one.				
700	In your opinion, is a husband justified in hitting or beating his wife if: she goes out without telling him?	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
701	If she neglects the children?	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
702	If she argues with him?	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
703	If she burns the food?	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
704	If she refuses to have sex with him?	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
705	Contraception is a woman's business and a man should not have to worry about it.	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
706	Women who use contraception may become promiscuous.	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
Now I would like to ask about your own actual situation in terms of marriage.				
707	Are you married?	0. No 1. Yes	_____	If 1, go to 708 and mention "spouse"; if 0, go to 710.
708	How old were you when you married?	[Age in years]	_____	

For interviewer completion only				
#	**Question**	**Response Choices**	**Entry**	**Skip Pattern**
709	How long had you known your (current/last) spouse before you married?	1. Met on the wedding day 2. Less than one month 3. 1 month to less than 1 year 4. 1 year or more 5. Other (specify): _____	_____	Go to 712
710	Are you engaged?	0. No 1. Yes	_____	If 1, go to 711 and mention "fiancée". If 0, go to 800.
711	How old were you when you got engaged?	[Age in years]	_____	
712	Who chose your spouse/ fiancee?	1. Respondent chose 2. Respondent and spouse/ fiancee chose each other 3. Respondent's family chose 4. Spouse's family chose	_____	If 1 or 2, go to 800.
713	When your spouse/fiancee was being chosen for you, were you asked whether you wanted to marry him/her of not?	0. No 1. Yes 88. No answer	_____	

Now I would like to read some statements for you about your attitude towards marriage in general. (Even if you were married a certain way/age, you may have a different opinion than what happened to you). You can respond with: strongly disagree (SDA), disagree (DA), neither disagree or agree (NDA/A), agree (A), and strongly agree (SA)

		SDA	**DA**	**NDA/A**	**A**	**SA**	**Response**
800	*It is better marrying at age 16 than at age 24 years*	05	04	03	02	01	
801	*Marriage should be before first menstruation*	05	04	03	02	01	
802	*The ideal age at marriage is less than 24 years old*	05	04	03	02	01	
803	*The ideal age at marriage is more than 24 years old*	05	04	03	02	01	
804	*Women should control when they marry*	05	04	03	02	01	
805	*Men should control when they marry*	05	04	03	02	01	
806	*It is better for young people to choose who they marry*	05	04	03	02	01	
807	*It is better for parents to choose who their children marry*	05	04	03	02	01	
808	*Parental consent (for marrying) is required*	05	04	03	02	01	
809	*Parents should have a young person's consent is required before marrying*	05	04	03	02	01	
810	*Love marriage is good*	05	04	03	02	01	
811	*It is better to know your future husband/wife before you marry*	05	04	03	02	01	
812	*It is acceptable to meet him/her on the day of the wedding*	05	04	03	02	01	

Now I would like to read some statements for you. You can respond with: strongly disagree (SDA), disagree (DA), neither disagree or agree (NDA/A), agree (A), and strongly agree (SA)

		SDA	DA	NDA/A	A	SA	Response
900	Husbands and wives in my community use family planning to space between births	05	04	03	02	01	
901	Women in my community get care for their pregnancies from health providers before delivery.	05	04	03	02	01	
902	Women in my community give birth at health facilities.	05	04	03	02	01	
903	Women in my community go to health facility/ talk to health workers about family planning methods	05	04	03	02	01	
904	Men in my community go to health facility/ talk to health workers about family planning methods	05	04	03	02	01	
905	Men in my community go to health facility/ talk to health workers about antenatal care and birth planning	05	04	03	02	01	
906	People in my community are supportive regarding family planning use	05	04	03	02	01	
907	People in my community are supportive regarding delivering in a health facility	05	04	03	02	01	
908	Men in my community are involved family planning	05	04	03	02	01	
909	Men in my community are involved birth preparedness planning	05	04	03	02	01	
910	I believe that frequent childbearing with short spacing between births is harmful to the health of the mother	05	04	03	02	01	
911	I believe that early (before age 18) childbearing is harmful to the health of the mother.	05	04	03	02	01	
912	I believe that using family planning methods to space children is safe	05	04	03	02	01	
913	Most family planning methods can removed anytime/stop anytime whenever you want to be pregnant	05	04	03	02	01	
914	Going to at least 4 ANC visits can help women have healthier babies	05	04	03	02	01	
915	Families are more prepared for having babies if husbands are involved in their wives' family planning use	05	04	03	02	01	
916	In case a woman experiences complications during delivery, she is more likely to get the help she needs at a health facility than if she gives birth at home	05	04	03	02	01	
917	Families are more likely to have healthy babies and mothers if husbands are involved in their wives' birth preparedness planning	05	04	03	02	01	
918	Families who use family planning to space their pregnancies have a better future than families who do not use family planning	05	04	03	02	01	
919	It is difficult for women to get family planning methods	05	04	03	02	01	
920	It is difficult for women to go to at least 4 antenatal visits during pregnancy	05	04	03	02	01	
921	It is difficult for pregnant women to access healthy foods.	05	04	03	02	01	

		SDA	DA	NDA/A	A	SA	Response
922	It is difficult for women to be able to give birth in health facilities	05	04	03	02	01	
923	It is difficult for infants to get care in health facilities	05	04	03	02	01	
924	My community wouldn't think it is appropriate for husbands to be involved in their wives' use of family planning methods	05	04	03	02	01	
925	My community wouldn't think it is appropriate for husbands to be involved in their wives pregnancies	05	04	03	02	01	

926	End time of interview	Hours written in 24 hour clock, for example 8 pm = 20:00 hours	_____hrs: _____min	Thank the participant for their time.

MALE MNCH COMMUNICATIONS SURVEY
QUANTITATIVE COMPONENT

Introduction

Thank you for agreeing to participate in this survey. I will be asking you questions about various issues regarding health and communication, both generally and as they pertain to you and your family. This conversation will last about 30 minutes and you can ask for a break at any time if you need one. Also, if any question is unclear or you would like to discuss it prior to answering, please ask me. You may also decline to answer any question you do not wish to answer. All of your answers are private and we will not be recording your name or other information that can identify you personally. Are you ready to begin the questionnaire?

Respondent agrees to be interviewed. ☐ Yes (go to 001) ☐ No (STOP)

For Field Manager Completion			
001	Survey code		
002	Interviewer code		
003	Supervisor code		
004	Have data been cleaned and are they complete?	**Supervisor signature:**	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
100	Source organization	1. ANA 2. ANP 3. Farmer's co-op 4. Community leader 5. Other	_____	
101	City/provincial district of interview	1. Kabul 2. Hirat 3. Mazar-i-Sharif 4. Kandahar 5. Jalalabad 6. Taloquan 7. Kama 8. Behsud 9. Khiwa 10. Farkhar 11. Rustaq 12. Enjil 13. Zenda Jan 14. Yakawlang 15. Daman	_____	
102	If city, please write district (*nahia*) number	[District number]	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
103	Province of Interview	1. Kabul 2. Hirat 3. Nangarhar 4. Kandahar 5. Balkh 6. Takhar 7. Bamiyan	_____	
104	Date of interview	Day/Month/Year using Gregorian calendar	_____ Day/ _____ Month/ _____ Year	
105	Start time of interview	Hours written in 24 hour clock, for example 8 pm = 20:00 hours	_____ hrs: _____ min	
We are asking for you to please provide a telephone number so we can complete quality assurance measures for this study; we may call you to verify that you completed the interview but we will not ask about any of your answers or any identifying information from you.				
106	Telephone number for quality assurance	[Enter telephone number]	_____	
107	Language of interview	1. Dari 2. Pashto 9. Other (specify): _____	_____	If other, thank participant and STOP interview.
Demographic Data				
200	How old (number of years) are you right now? Please make your best guess.	Number of years (98=don't know year)	_____	
201	Were you born in Afghanistan?	0. No 1. Yes	_____	If 0, go to 203; if 1, go to 204.
202	In what country were you born?	1. Pakistan 2. Iran 3. Tajikistan 4. India 5. Arab Emirates 6. Other (specify): _____	_____	Go to 205.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
203	In what province were you born?	1. Badghis 2. Baghlan 3. Badakhshan 4. Balkh 5. Bamiyan 6. Daikundi 7. Farah 8. Faryab 9. Ghazni 10. Ghor 11. Helmand 12. Herat 13. Jawzjan 14. Kabul 15. Kandahar 16. Kapisa 17. Khost 18. Kunar 19. Kunduz 20. Laghman 21. Logar 22. Nangahar 23. Nimroz 24. Nuristan 25. Paktia 26. Paktika 27. Panjshir 28. Parwan 29. Samangan 30. Saripul 31. Takhar 32. Uruzgan 33. Wardak 34. Zabul	_____	Go to 205.
204	Is your current home (where your family lives even if you are away working) in the same province where you were born?	0. No 1. Yes	_____	If 0, go to 206; if 1, go to 207.
205	If no, in what province is your current home located?	1. Badghis 2. Baghlan 3. Badakhshan 4. Balkh 5. Bamiyan 6. Daikundi 7. Farah 8. Faryab 9. Ghazni 10. Ghor 11. Helmand 12. Herat 13. Jawzjan 14. Kabul 15. Kandahar 16. Kapisa 17. Khost 18. Kunar 19. Kunduz 20. Laghman 21. Logar 22. Nangahar 23. Nimroz 24. Nuristan 25. Paktia 26. Paktika 27. Panjshir 28. Parwan 29. Samangan 30. Saripul 31. Takhar 32. Uruzgan 33. Wardak 34. Zabul	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
206	In your current home, what is the main source of income?	1. Agriculture 2. Rearing animals 3. Service/salaried 4. Business/trading 5. Remittance 6. Seasonal Worker 7. Labor (daily wages) 8. Other (specify): _____	_____	
207	In your current home, what is the main material used for the floor?	1. Wood 2. Mud 3. Tile/brick 4. Concrete 5. Other (specify): _____	_____	
208	What would you estimate is the monthly income level of your household?	Number in Afs. Put in 0's before first number to fill all spaces. If unknown, insert 999999 in all spaces.	_____ Afs	
The next question will ask about common things people may have in their homes. We are asking this question so we are able to compare answers between similar and different people and this is one way of understanding important differences between households when we consider peoples' different health needs.				
209 a-m.	Does your family (with whom you are living) own any of the following? Please, include only those that work, not broken. [INTERVIEWER: READ EACH ITEM OUT LOUD. MARK Yes (1) or No (2) for each item.]	a. Refrigerator b. Stove/gas cooker c. Radio d. Television e. DVD player f. Satellite phone g. Mobile phone without internet h. Mobile "Smart" phone with internet i. Bicycle j. Motorcycle k. Car m. None of the above	a. _____ b. _____ c. _____ d. _____ e. _____ f. _____ g. _____ h. _____ i. _____ j. _____ k. _____ m. _____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
210	What is the main source of drinking water within your household?	1. Piped water into dwelling 2. Piped water to yard/plot 3. Public tap/standpipe 4. Tube well or borehole 5. Dug well 6. Protected well 7. Unprotected well 8. Protected spring 9. Unprotected spring 10. Rainwater 11. Tanker truck 12. Cart with small tank/drum 13. Surface water (river/dam/ lake/pond/stream/canal/ 14. irrigation channel) 15. Bottled water 16. Other (specify): _____	_____	
211	Have you ever attended school?	0. No 1. Yes	_____	
212	Are you currently a student?	0. No 1. Yes	_____	
213	What is the highest level of school you attended: primary, secondary, or higher?	1. Primary 2. Secondary 3. Higher 4. Vocational 5. Madrassa	_____	
214	What is the highest grade you completed? IF COMPLETED LESS THAN GRADE ONE, RECORD '00'.	Insert class level/ number	_____	If more than 6th grade, go to 216.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
215	Now could you please read this sentence to me? [Show participant the card] [If participant cannot read the whole sentence:] Can you read any part of the sentence to me?	1. Cannot read at all 2. Can read part of the sentence 3. Can read all of the sentence 4. Blind/visually impaired	_____	
216	What is your current marital status?	1. Never married 2. Currently married 3. Divorced 4. Widowed	_____	If 1, 3, or 4, go to 218.
217	If married, how many wives do you currently have?	[Write number]	_____	
218	To which ethnic group (milat) do you belong?	1. Pashtun 2. Tajik 3. Hazara 4. Uzbek 5. Turkmen 6. Nuristani 7. Baluch 8. Pashai 9. Other (specify): _____	_____	
Media Exposure and Preferences				
300	How often do you read a newspaper or magazine?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If not at all, go to 304.
301	What type of information do you read in a newspaper or magazine? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. News/ Current events 2. Political/religious commentary 3. Sports 4. Entertainment 5. Job advertisements 6. Other (specify): _____	_____ _____ _____	
302	Have you received health information from a newspaper or magazine in the last 30 days?	0. No 1. Yes	_____	If no, go to 304.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
303	What was this information regarding? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/ 5. hygiene 6. Nutrition 7. High blood pressure 8. Smoking cigarettes 9. Other (specify): _____	_____ _____ _____	
304	How often do you listen to the radio?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If not at all, go to 310.
305	At what times do you usually listen to the radio?	1. 0:00 – < 6:00 2. 6:00 – < 9:00 3. 9:00 – < 12:00 4. 12:00 – < 15:00 5. 15:00 – < 18:00 6. 18:00 – <21:00 7. 21:00 – < 24:00	_____ _____ _____	
306	What type of information do you listen to on the radio? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. International news 2. National news 3. Local news 4. Music 5. Religious 6. Culture 7. Political debates 8. Entertainment 9. Health 10. Social 11. Drama 12. Other (specify): _____	_____ _____ _____	
307	Have you received health information from the radio in the last 30 days?	0. No 1. Yes	_____	If no, go to 310.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
308	What was this information regarding? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/ 5. hygiene 6. Nutrition 7. High blood pressure 8. Smoking cigarettes 9. Other (specify): _____	_____ _____ _____	
309	What are the two radio stations you listen to most frequently?	[Write out station names]	_____	
310	How often do you watch television?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If not at all, go to 316.
311	At what times do you usually watch television?	1. 0:00 – < 6:00 2. 6:00 – < 9:00 3. 9:00 – < 12:00 4. 12:00 – < 15:00 5. 15:00 – < 18:00 6. 18:00 – <21:00 7. 21:00 – < 24:00	_____ _____ _____	
312	What type of information do you watch on television? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. International news 2. National news 3. Local news 4. Drama 5. Music 6. Religious 7. Entertainment 8. Movies 9. Political debate 10. Educational programs 11. Other (specify): _____	_____ _____ _____	
313	Have you received health information from television in the last 30 days?	0. No 1. Yes	_____	If 0, go to 315.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
314	What was this information regarding? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/ 5. hygiene 6. Nutrition 7. High blood pressure 8. Smoking cigarettes 9. Other (specify): _____	_____ _____ _____	
315	What are the two television channels you watch most frequently?	[Write names of channels]	_____ _____	
316	Do you own a mobile phone for your own personal use?	0. No 1. Yes 88. No Answer	_____	If 1 or 88, go to 318.
317	Do you know someone (i.e. friend or neighbor) who owns a mobile phone you could use if you needed to do so?	0. No 1. Yes 88. No Answer 99. Don't Know	_____	
318	Have you ever used Internet on any of the following: a computer, a smart phone, and/or a tablet?	0. No 1. Yes 88. No Answer	_____	If 1 or 88, go to 324.
319	Have you ever accessed the internet?	0. No 1. Yes 88. No Answer	_____	
320	How often do you access the internet?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If 4, go to 324.
321	What type of information do you get from the internet? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Email / social media 2. Current events 3. Political/religious commentary 4. Sports 5. Entertainment 6. Job advertisements 7. Other (specify): _____	_____ _____ _____	
322	Have you received health information from the internet in the last 30 days?	0. No 1. Yes	_____	If 0, go to 324.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
323	What was this information regarding? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/hygiene 5. Nutrition 6. High blood pressure 7. Smoking cigarettes 8. Other (specify): _____	_____ _____ _____	
324	Have you received care from any medical provider in the last 6 months?	0. No 1. Yes	_____	If 0, go to 327.
325	If yes, did you receive any counseling or instruction on how to improve/maintain your health?	0. No 1. Yes	_____	If 0, go to 327.
326	On what topic(s) did you receive information? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Health maintenance (exercise/ nutrition) 2. Smoking cessation 3. Accident prevention 4. Stress reduction 5. Depression or other mental health issues 6. Family planning 7. Women's health 8. Child health 9. Other (specify): _____	_____ _____ _____	
327	Where do you generally get information about health? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Family member 2. Friend 3. Religious leader/mullah 4. Village leader 5. Doctor/nurse/midwife 6. Community health worker 7. Television 8. Radio 9. Internet 10. Newspaper 11. Telephone hotline/program 88. No Answer 99. Don't Know	_____	
328	In the last 12 months, have you received any information about care during pregnancy or at time of delivery?	0. No 1. Yes 88. No Answer	_____	If 0 or 8, go to 329. If 1, go to table on next page (331).

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
329	In the last 12 months, have you received any information about child health, including advice about breastfeeding and other child feeding?	0. No 1. Yes 88. No Answer	_____	If 0 or 8, go to 330. If 1, go to table on next page (334).
330	In the last 12 months, have you received any information about birth spacing or avoiding pregnancy?	0. No 1. Yes 88. No Answer	_____	If 0 or 8, go to 340. If 1, go to table on next page (337).

In the table below, please ask the question in each column and enter the number for the source reported by the participant. The participant may provide the answer for more than one question at one time. If so, please mark the answer without re-asking the question. Please do NOT read the entire list of sources but only enter the number in the question response box for the one(s) stated by the participant.

Response Choices	331. Where did you receive information about pregnancy & childbirth? (multiple answers allowed)	332. Which source was most convenient? (One answer only)	333. Which source was most informative/ accurate? (One answer only)	334. Where did you receive information on breastfeeding or child health?	335. Which source was most convenient? (One answer only)	336. Which source was most informative/ accurate? (One answer only)	337. Where did you receive information about birth spacing or avoiding pregnancy?	338. Which source was most convenient? (One answer only)	339. Which source was most informative/ accurate? (One answer only)
0. Did not receive information									
1. Family member									
2. Friend									
3. Religious leader/ mullah									
4. Village leader									
5. Doctor/ 6. midwife/ 7. nurse									
8. Community health worker									
9. Television									
10. Radio									
11. Internet									

Response Choices	331. Where did you receive information about pregnancy & childbirth? (multiple answers allowed)	332. Which source was most convenient? (One answer only)	333. Which source was most informative/ accurate? (One answer only)	334. Where did you receive information on breastfeeding or child health?	335. Which source was most convenient? (One answer only)	336. Which source was most informative/ accurate? (One answer only)	337. Where did you receive information about birth spacing or avoiding pregnancy?	338. Which source was most convenient? (One answer only)	339. Which source was most informative/ accurate? (One answer only)
12. Newspaper									
13. Telephone hotline/ program									
88. No answer									
99. Don't know									

STUDY STAFF: **After 333, go to 329.**
After 336, go to 330.
After 339, go to 340.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Patter
340	If additional information about birth spacing or protecting the health of mothers and children were available, what ways would be best to reach you? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Discussion with healthcare provider 2. Home visit with a community-based health worker 3. Printed information 4. Television 5. Radio 6. Send information by mobile phone in voice call 7. Telephone hotline 8. Other (specify): _____ 88. No Answer 99. Don't Know	_____ _____ _____	
341	Of the choices you just mentioned, which one way would you prefer most to receive new information about family planning or protecting the health of mothers and children?	1. Discussion with healthcare provider 2. Home visit with a community-based health worker 3. Printed information 4. Television 5. Radio 6. Send information by mobile phone in voice call 7. Telephone hotline 8. Other (specify): _____ 88. No answer 99. Don't know	_____	
342	Do you feel you need more information about how to ensure good health for your family?	1. No 2. Yes 88. No answer 99. Don't know	_____	If 0, 88, or 99, go to 400.
343	If yes, for what health areas would you want further information? (INTERVIEWER: Please enter all choice numbers mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Care during pregnancy before birth 2. Care during the birth process 3. Best care for a healthy newborn 4. Instructions on breastfeeding and best infant feeding practices 5. Information about nutrition and feeding your family 6. Information about birth spacing methods 7. Other (specify): _____	_____ _____ _____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Patter
Now, I would like to ask you a few questions about woman's and children's health.				
400	A pregnant woman should go for regular antenatal check-ups even if they are not sick. What do you think of that statement?	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
401	Women should have at least 4 antenatal care visits during pregnancy.	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
402	In your opinion, what are some serious health problems that can occur during pregnancy that could endanger the life of a pregnant woman? I am referring to the months of pregnancy, not to the birth itself. (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Bleeding 2. Severe Headache 3. Blurred Vision 4. Convulsions 5. Swollen Hands/Face 6. Fever 7. Loss of Consciousness 8. Difficulty Breathing 9. Severe Weakness 10. Severe Abdominal Pain 11. Reduced Fetal Movement 12. Water Breaks without Labor 13. Other (specify): _____ 14. None 88. No answer 99. Don't know	_____ _____ _____	
403	In your opinion, could a woman die from any of these problems?	0. No 1. Yes 88. No answer 99. Don't know	_____	
404	Are women who become pregnant before age 18 at greater, the same, or lower risk of having complications with the pregnancy as women aged 18 to 34?	1. Greater risk 2. The same risk 3. Lower risk 88. No answer 99. Don't know	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Patter
405	What could a woman do to make sure her health is safe during pregnancy? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Go for regular antenatal health checkups to a midwife or doctor 2. Take traditional medicine 3. Avoid inappropriate foods 4. Consult the religious leader/ mullah 5. Consult a dayee/hakim-ji 6. Consult her mother-in-law/ mother 7. Other (specify): _____ 8. Nothing 88. No answer 99. Don't know	_____ _____ _____	
406	If your wife were to experience any danger signs/ symptoms during pregnancy, what actions would you take? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Go to a health facility 2. Buy medicine from pharmacy/ shop 3. Seek the help of dayee 4. Seek the help of a religious leader 5. Seek the help of relatives 6. Other (specify): _____ 7. Take no action 88. No answer 99. Don't know	_____ _____ _____	
407	In your opinion, where is the best place for a woman to give birth?	1. At a health facility 2. At home 3. Other (specify): _____ 88. No answer 99. Don't know	_____	
408	For what reasons do you think that is the best place for a woman to deliver a baby? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Less expensive 2. Safer 3. Better care 4. Easy to access 5. Privacy 6. Tradition 7. Other (specify): _____ 88. No answer	_____ _____ _____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Patter
409	In your opinion, what are some serious health problems that can occur during labor and childbirth that could endanger the life of a pregnant woman? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Severe Bleeding 2. Convulsions 3. High Fever 4. Loss of Consciousness 5. Labor Lasting > 12 Hours 6. Position of the baby is "wrong" 7. Placenta Not Delivered 30 Minutes After Baby 8. Other (specify): _____ 9. None 88. No answer 99. Don't know	_____ _____ _____	
410	In your opinion, could a woman die from any of these problems?	0. No 1. Yes 88. No answer 99. Don't know	_____	
411	In your opinion, what are some of the things a woman and her family can do to prepare for birth? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Go to a health facility 2. Move temporarily to stay closer to a facility 3. Identify Mode of Transport to health facility 4. Save Money 5. Identify Blood Donor 6. Identify Skilled Provider 7. Other (specify): _____ 8. Nothing 88. No answer 99. Don't know	_____ _____ _____	
412	In your opinion, what is the best way to care for the umbilical cord after cutting? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Keep it dry 2. Use chlorhexidine to clean daily for 1 week 3. Apply something else to the remaining cord 4. Other (specify): _____ 88. No answer 99. Don't know	_____ _____ _____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Patter
413	In your opinion, what is/are the best way(s) to maintain the baby's body temperature after birth? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Put hat on baby's head 2. Keep baby well wrapped in swaddling 3. Keep baby wrapped on the mother's chest 4. Delay bathing the baby 5. Make sure the room is warm 6. Other (specify): _____ 88. No answer 99. Don't know	_____ _____ _____	
414	How long after birth should a newborn start breastfeeding?	1. Within one hour 2. Within several hours 3. Within one day 4. Within several days 5. When the white milk comes in 88. No answer 99. Don't know	_____	
415	Which is better for an infant younger than 6 months, breast milk alone or a combination of breast milk and infant formula?	1. Breast milk alone 2. Combination of breast milk and infant formula 88. No answer 99. Don't know	_____	
416	Until what month of age should a mother do the following things: Give her infant ONLY breast milk and NO other foods, water or infant formula?	Months in number 88. No answer 99. Don't know (Enter numbers and place 0 before the number if the response is a single number)	_____	
417	Continue breastfeeding even if providing complementary food?	Months in numbers 88. No answer 99. Don't know (Enter numbers and place 0 before the number if the response is a single number)	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Patter
We will now ask you some questions about family planning. Please let me know if you need to take a break before we start the new set of questions. You are doing very well.				
500	Now I would like to ask you about a woman's risk of pregnancy. From one menstrual period to the next, have you heard if there certain days when a woman is more likely to become pregnant when she has sexual relations?	0. No 1. Yes 88. No answer 99. Don't know	_____	If 0, 88, or 99, please go to 502.
501	Is this time just before her period begins, during her period, right after her period has ended, or halfway between two periods?	1. Just before her period 2. During her period 3. Right after her period has ended 4. Halfway between two periods 88. No answer 99. Don't know	_____	
502	Have you ever heard of ways or methods that a couple can use to delay or avoid a pregnancy?	0. No 1. Yes 88. No answer	_____	If 0, go to 504.
503	Which ways or methods have you heard of? (INTERVIEWER: Please list all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. IUD/ loop 2. Condoms 3. Oral contraceptives 4. Injectable contraceptives 5. Implant 6. Female sterilization 7. Male sterilization 8. Rhythm method/standard days 9. Withdrawal 10. Lactational amenorrhea 11. Emergency contraception	_____ _____ _____	
504	For how many months after a baby is born will exclusive breastfeeding (meaning breast milk only is given to the baby, no solid food or other liquids) be effective for preventing pregnancy?	Number of months 88. No answer 99. Don't know	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Patter
Please indicate whether you agree with the following statements regarding family planning:				
505	Using pills or injections can make it impossible for a woman to become pregnant after discontinuing use	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
506	Withdrawal is a highly effective method for preventing pregnancy	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
507	The IUD or loop can prevent pregnancy for up to 10 years.	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
508	Irregular periods or bleeding between periods while using the injection or implant will usually resolve on its own.	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
Attitudes, Care Utilization, and Decision-making				
600	Have you been to a health facility for care for yourself in the last three months?	0. No 1. Yes 88. No answer	_____	
601	Have you met with a community health worker in the last three months?	0. No 1. Yes 88. No answer	_____	
602	Does your community have a shura e sehie?	0. No 1. Yes 88. No answer	_____	If 0 or 8, go to 604.
603	In the last three months, have you met with a member of the shura e sehie about a health matter?	0. No 1. Yes 88. No answer	_____	
604	Does your community have a family health action group?	0. No 1. Yes 88. No answer	_____	If 0 or 8, go to 606.
605	In the last three months, have you met with a member of the family health action group about a health matter?	0. No 1. Yes 88. No answer	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Patter
606	When you have a question about a general health issue, what source do you usually consult for information? (INTERVIEWER: Please list all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Spouse 2. Father/mother 3. Brother/sister 4. Other family member 5. Friend 6. Religious leader 7. Internet 8. Book/magazine 9. Doctor/midwife 10. Community health worker 11. Hotline/Call center 12. Other (specify): _____	_____ _____ _____	
607	How about when you have a reproductive health issue? Please list the first person or resource you would go to, followed by the second, etc. (INTERVIEWER: Please list all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Spouse 2. Father/ mother 3. Brother/sister 4. Other family member 5. Friend 6. Religious leader 7. Internet 8. Book/magazine 9. Doctor/midwife 10. Community health worker 11. Hotline/Call center 12. Other (specify): _____ 13. No one 88. No answer	_____ _____ _____	If 13 or 88, go to 609.
608	If there were a free mobile phone based information project for reproductive health, how likely would you be to use it?	1. Very likely 2. Somewhat likely 3. Neither likely nor unlikely 4. Somewhat unlikely 5. Very unlikely/wouldn't use	_____	
609	If you used this mobile phone program for advice on family planning and general health, would you prefer to hear a recorded message or speak to a live person?	1. Hear a recorded message 2. Speak to a live person 99. Don't know	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Patter
I will now read you some statements about family decision-making that involve female members of your family. We are asking these questions to better understand what health information men provide to their wives and how much couples talk about health issues and decisions. These questions may be sensitive and you are welcome to ask me about why these questions are here. Please remember you may decline to answer a question at any time. If you agree, can we proceed? (If agrees, then proceed with next statement) Please tell me if you agree or disagree with each one.				
700	In your opinion, is a husband justified in hitting or beating his wife if: she goes out without telling him?	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
701	If she neglects the children?	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
702	If she argues with him?	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
703	If she burns the food?	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
704	If she refuses to have sex with him?	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
705	Contraception is a woman's business and a man should not have to worry about it.	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
706	Women who use contraception may become promiscuous.	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	

Now I would like to read some statements for you. You can respond with: strongly disagree (SDA), disagree (DA), neither disagree or agree (NDA/A), agree (A), and strongly agree (SA)

		SDA	DA	NDA/A	A	SA	Response
800	*Husbands and wives in my community use family planning to space between births*	05	04	03	02	01	
801	*Women in my community get care for their pregnancies from health providers before delivery.*	05	04	03	02	01	
802	*Women in my community give birth at health facilities.*	05	04	03	02	01	

		SDA	DA	NDA/A	A	SA	Response
803	*Women in my community go to health facility/ talk to health workers about family planning methods*	05	04	03	02	01	
804	*Men in my community go to health facility/ talk to health workers about family planning methods*	05	04	03	02	01	
805	*Men in my community go to health facility/ talk to health workers about antenatal care and birth planning*	05	04	03	02	01	
806	*People in my community are supportive regarding family planning use*	05	04	03	02	01	
807	*People in my community are supportive regarding delivering in a health facility*	05	04	03	02	01	
808	*Men in my community are involved family planning*	05	04	03	02	01	
809	*Men in my community are involved birth preparedness planning*	05	04	03	02	01	
810	*I feel confident that my wife and I can use family planning to space between births*	05	04	03	02	01	
811	*I feel knowledgeable when discussing birth spacing with my wife*	05	04	03	02	01	
812	*I feel knowledgeable discussing a birth plan with my wife*	05	04	03	02	01	
813	*I feel knowledgeable discussing health care for the children with my wife*	05	04	03	02	01	
814	*I feel confident asking my wife about family planning methods*	05	04	03	02	01	
815	*I feel confident that I can save money to support my family in case of emergency during pregnancy or delivery*	05	04	03	02	01	
816	*I believe that frequent childbearing with short spacing between births is harmful to the health of the mother*	05	04	03	02	01	
817	*I believe that early (before age 18) childbearing is harmful to the health of the mother.*	05	04	03	02	01	
818	*I believe that using family planning methods to space children is safe*	05	04	03	02	01	
819	*Most family planning methods can removed anytime/ stop anytime whenever you want to be pregnant*	05	04	03	02	01	
820	*Going to at least 4 ANC visits can help women have healthier babies*	05	04	03	02	01	
821	*Families are more prepared for having babies if husbands are involved in their wives' family planning use*	05	04	03	02	01	
822	*In case a woman experiences complications during delivery, she is more likely to get the help she needs at a health facility than if she gives birth at home*	05	04	03	02	01	
823	*Families are more likely to have healthy babies and mothers if husbands are involved in their wives' birth preparedness planning*	05	04	03	02	01	

		SDA	DA	NDA/A	A	SA	Response
824	*Families who use family planning to space their pregnancies have a better future than families who do not use family planning to space their pregnancies*	05	04	03	02	01	
825	*It is difficult for women to get family planning methods*	05	04	03	02	01	
826	*It is difficult for women to go to at least 4 antenatal visits during pregnancy*	05	04	03	02	01	
827	*It is difficult for pregnant women to access healthy foods.*	05	04	03	02	01	
828	*It is difficult for women to be able to give birth in health facilities*	05	04	03	02	01	
829	*It is difficult for infants to get care in health facilities*	05	04	03	02	01	
830	*My community wouldn't think it is appropriate for husbands to be involved in their wives' use of family planning methods*	05	04	03	02	01	
831	*My community wouldn't think it is appropriate for husbands to be involved in their wives pregnancies*	05	04	03	02	01	
832	*I support the use of FP to space our children*	05	04	03	02	01	
833	*My mother supports using family planning methods for spacing*	05	04	03	02	01	
834	*My mother supports the decision for my wife to deliver at a health facility*	05	04	03	02	01	
835	*Men like me believe that a husband's involvement in family planning is good*	05	04	03	02	01	
836	*Men like me believe that spousal communication on birth spacing will help on acceptance of family planning method*	05	04	03	02	01	
837	*Men like me believe that care during pregnancy is essential*	05	04	03	02	01	
838	*Men like me believe that delivery at a health facility is safe*	05	04	03	02	01	

INTERVIEWER: Consult Q 216 to determine if the participant is married. Proceed with section if participant is married; skip to if he is not currently married.

#	Question	Response Choices	Entry	Skip Pattern
900	Who usually decides how the money you earn will be used: you, your wife, or you and your wife jointly?	1. Respondent alone 2. Wife alone 3. Respondent and wife jointly 4. Other family member 5. Other (specify): _____	_____	

#	Question	Response Choices	Entry	Skip Pattern
901	Who usually makes decisions about making major household purchases?	1. Respondent alone 2. Wife alone 3. Respondent and wife jointly 4. Other family member 5. Other (specify): _____	_____	
902	Who usually makes decisions about health care for your family?	1. Respondent alone 2. Wife alone 3. Respondent and wife jointly 4. Other family member 5. Other (specify): _____	_____	
903	Do you have children?	0. No 1. Yes	_____	If 0, go to 905.
904	How many living children do you currently have?	Enter number with 0 in front of single digit answer	_____	
905	Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children?	0. No 1. Yes 8. No answer 9. Don't know	_____	If 0, 8, or 9, go to 908.
906	How many more children would you like?	Enter number with 0 in front of single digit answer	_____	
907	How long would you like to wait from now before the birth of (a/another) child?	Number of months	_____	
908	Are you and your wife using any method to delay or avoid pregnancy at this time?	1. No, don't want 2. No, wife is currently pregnant 3. Yes 8. No answer	_____	If 1, 2, or 8, go to 910.
909	If yes, which method(s)? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. IUD/ loop 2. Condoms 3. Oral contraceptives 4. Injectable contraceptives 5. Implant 6. Female sterilization 7. Male sterilization 8. Rhythm method/standard days 9. Withdrawal 10. Lactational amenorrhea 11. Emergency contraception	_____ _____ _____	If no children (see question 904 above), FINISH
910	Has your wife had a pregnancy in the last two years?	0. No 1. Yes 88. No answer	_____	If no or no answer, FINISH

#	Question	Response Choices	Entry	Skip Pattern
911	In your wife's last pregnancy, did she see a medical provider for care during the pregnancy?	0. No 1. Yes 88. No answer 99. Don't know	_____	
912	How many times did she go for medical checks during her pregnancy?	Enter number of times. Place 0 in front of number if it is a single digit. 88. No answer 99. Don't know	_____	
913	At medical care visits during her pregnancy, did the medical provider ever speak with you?	0. No 1. Yes 2. Did not see a health care provider during pregnancy 88. No answer 99. Don't know	_____	
914	Did your wife receive/take iron tablets during her last pregnancy?	0. No 1. Yes 88. No answer	_____	
915	Where was the baby delivered?	1. Public (MoPH) clinic 2. Public (MoPH) hospital 3. Private clinic/hospital 4. Health post/CHW's house 5. Home 6. Other (specify): _____	_____	
916	Who was the main person who assisted with this delivery?	1. Doctor 2. Nurse 3. Midwife 4. CHW 5. Relative/Friend 6. No one 7. Other (specify): _____ 99. Don't know	_____	
917	Did your wife visit a medical provider or did the provider come to the house to check on her after delivery?	0. No 1. Yes 88. No answer 99. Don't know	_____	
918	How many times did she go for medical checks after the delivery?	Enter total number 88. No answer 99. Don't know	_____	
919	Was the infant breastfed?	1. No (baby died) 2. No (baby living) 3. Yes 88. No answer 99. Don't know	_____	

920	End time of interview	Hours written in 24 hour clock, for example 8 pm = 20:00 hours	_____ hrs: _____ min	Thank the participant for their time.

SCHOOL-BASED YOUTH MNCH COMMUNICATIONS SURVEY
QUANTITATIVE COMPONENT

Introduction

Thank you for agreeing to participate in this survey. I will be asking you questions about various issues regarding health and communication, both generally and as they pertain to you and other people your age. This conversation will last about 30 minutes and you can ask for a break at any time if you need one. Also, if any question is unclear or you would like to discuss it prior to answering, please ask me. You may also decline to answer any question you do not wish to answer. All of your answers are private and we will not be recording your name or other information that can identify you personally. Are you ready to begin the questionnaire?

Respondent agrees to be interviewed ☐ Yes (go to 001) ☐ No (STOP)

For field manager completion:			
001	Survey code		
002	Interviewer code		
003	Supervisor code		
004	Have data been cleaned and are they complete?	*Supervisor signature:*	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
100	Source organization	1. GIHS 2. Secondary school 3. Other	_____	
101	City/district of interview	1. Kabul 2. Hirat 3. Mazar-i-Sharif 4. Kandahar 5. Jalalabad 6. Kama	_____	
102	If city, please write district (nahia) number	District number	_____	
103	Province of interview	1. Kabul 2. Hirat 3. Nangarhar 4. Kandahar 5. Balkh 6. [TBD]	_____	
104	Date of interview	Day/ Month/Year using Gregorian calendar	_____ Day/ _____ Month/ _____ Year	
105	Start time of interview	Hours written in 24 hour clock, for example 8 pm = 20:00 hours	_____ hrs: _____ min	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
We are asking for you to please provide a telephone number so we can complete quality assurance measures for this study; we may call you to verify that you completed the interview but we will not ask about any of your answers or any identifying information from you.				
106	Telephone number for quality assurance	[Enter telephone number]	_____	
107	Language of interview	1. Dari 2. Pashto 9. Other (specify): _____	_____	If other, thank participant and STOP interview.
Demographic Data				
200	How old (number of years) are you right now? Please make your best guess.	Number of years (98=don't know year)	_____	
201	Were you born in Afghanistan?	0. No 1. Yes	_____	If 0, go to 203; if 1, go to 204.
202	In what country were you born?	1. Pakistan 2. Iran 3. Tajikistan 4. India 5. Arab Emirates 9. Other (specify): _____	_____	Go to 205.
203	In what province were you born?	1. Badghis 2. Baghlan 3. Badakhshan 4. Balkh 5. Bamiyan 6. Daikundi 7. Farah 8. Faryab 9. Ghazni 10. Ghor 11. Helmand 12. Herat 13. Jawzjan 14. Kabul 15. Kandahar 16. Kapisa 17. Khost 18. Kunar 19. Kunduz 20. Laghman 21. Logar 22. Nangahar 23. Nimroz 24. Nuristan 25. Paktia 26. Paktika 27. Panjshir 28. Parwan 29. Samangan 30. Saripul 31. Takhar 32. Uruzgan 33. Wardak 34. Zabul	_____	Go to 204.
204	Is your current home (where your family lives even if you are away attending school) in the same province where you were born?	0. No 1. Yes	_____	If no, go to 205; if yes, go to 206.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
205	In what province is your current home located?	1. Badghis 2. Baghlan 3. Badakhshan 4. Balkh 5. Bamiyan 6. Daikundi 7. Farah 8. Faryab 9. Ghazni 10. Ghor 11. Helmand 12. Herat 13. Jawzjan 14. Kabul 15. Kandahar 16. Kapisa 17. Khost 18. Kunar 19. Kunduz 20. Laghman 21. Logar 22. Nangahar 23. Nimroz 24. Nuristan 25. Paktia 26. Paktika 27. Panjshir 28. Parwan 29. Samangan 30. Saripul 31. Takhar 32. Uruzgan 33. Wardak 34. Zabul	_____	
206	In your current home, what is the main source of income?	1. Agriculture 2. Rearing animals 3. Service/salaried 4. Business/trading 5. Remittance 6. Seasonal Worker 7. Labor (daily wages) 9. Other (specify): _____	_____	
207.	In your current home, what is the main material used for the floor?	1. Wood 2. Mud 3. Tile/brick 4. Concrete 9. Other (specify): _____	_____	
208.	What would you estimate is the monthly income level of your household?	Number in Afs. Put in 0's before first number to fill all spaces. If unknown, insert 999999 in all spaces.	_____ Afs	
The next question will ask about common things people may have in their homes. We are asking this question so we are able to compare answers between similar and different people and this is one way of understanding important differences between households when we consider peoples' different health needs.				

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
209 a-m.	Does your family (with whom you are living) own any of the following? Please, include only those that work, not broken. [INTERVIEWER: READ EACH ITEM OUT LOUD. MARK Yes (1) or No (2) for each item.]	a. Refrigerator b. Stove/gas cooker c. Radio d. Television e. DVD player f. Satellite phone g. Mobile phone without internet h. Mobile "Smart" phone with internet i. Bicycle j. Motorcycle k. Car m. None of the above	a. _____ b. _____ c. _____ d. _____ e. _____ f. _____ g. _____ h. _____ i. _____ j. _____ k. _____ m. _____	
210	What is the main source of drinking water within your household?	1. Piped water into dwelling 2. Piped water to yard/plot 3. Public tap/standpipe 4. Tube well or borehole 5. Dug well 6. Protected well 7. Unprotected well 8. Protected spring 9. Unprotected spring 10. Rainwater 11. Tanker truck 12. Cart with small tank/drum 13. Surface water (river/dam/ lake/pond/stream/canal/ 14. irrigation channel) 15. Bottled water 16. Other (specify): _____	_____	
211	Are you currently a student?	0. No 1. Yes	_____	
212	What is the highest level of school you attended: primary, secondary, or higher?	1. Primary 2. Secondary 3. Higher 4. Vocational 5. Madrassa	_____	
213	What is the highest grade you completed?	Enter number with 0 first if the number is a single digit. If completed less than grade one, record '00'.	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
214	To which ethnic group (milat) do you belong?	1. Pashtun 2. Tajik 3. Hazara 4. Uzbek 5. Turkmen 6. Nuristani 7. Baluch 8. Pashai 9. Other (specify): _____	_____	
Media Exposure and Preferences				
300	How often do you read a newspaper or magazine?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If 4, go to 304.
301	What type of information do you read in a newspaper or magazine? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. News/ Current events 2. Political/religious commentary 3. Sports 4. Entertainment 5. Job advertisements 6. Other (specify): _____	_____ _____ _____	
302	Have you received health information from a newspaper or magazine in the last 30 days?	0. No 1. Yes	_____	If 0, go to 304.
303	What was this information regarding? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/hygiene 5. Nutrition 6. High blood pressure 7. Smoking cigarettes 8. Other (specify): _____	_____ _____ _____	
304	How often do you listen to the radio?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If not at all, go to 310.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
305	At what times do you usually listen to the radio?	1. 0:00 – < 6:00 2. 6:00 – < 9:00 3. 9:00 – < 12:00 4. 12:00 – < 15:00 5. 15:00 – < 18:00 6. 18:00 – <21:00 7. 21:00 – < 24:00		
306	What type of programming do you listen to on the radio? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. International news 2. National news 3. Local news 4. Music 5. Religious 6. Sports 7. Culture 8. Political debates 9. Entertainment 10. Health 11. Social 12. Drama 13. Other (specify): _____	_____ _____ _____	
307	Have you received health information from the radio in the last 30 days?	0. No 1. Yes		If 0, go to 309.
308	What was this information regarding? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/hygiene 5. Nutrition 6. High blood pressure 7. Smoking cigarettes 8. Other (specify): _____	_____ _____ _____	
309	What are the two radio stations you listen to most frequently?	[Write out station names]	_____ _____	
310	How often do you watch television?	Every or almost every day At least once weekly Less than weekly Not at all	_____	If 4, go to 316

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
311	At what times do you usually watch television?	1. 0:00 – < 6:00 2. 6:00 – < 9:00 3. 9:00 – < 12:00 4. 12:00 – < 15:00 5. 15:00 – < 18:00 6. 18:00 – <21:00 7. 21:00 – < 24:00	_____	
312	What type of programs do you watch on television? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. International news 2. National news 3. Local news 4. Drama 5. Music 6. Religious 7. Sports 8. Entertainment 9. Movies 10. Political debate 11. Educational programs 12. Other (specify): _____	_____ _____ _____	
313	Have you received health information from television in the last 30 days?	0. No 1. Yes	_____	If 0, go to 315.
314	What was this information regarding? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/ 5. hygiene 6. Nutrition 7. High blood pressure 8. Smoking cigarettes 9. Other (specify): _____	_____ _____ _____	
315	What are the two television channels you watch most frequently?	[Write out station names]	_____ _____	
316	Do you own a mobile phone for your own personal use?	0. No 1. Yes 88. No answer		If 1 or 8, go to 318.
317	Do you know someone (i.e. friend or neighbor) who owns a mobile phone you could use if you needed to do so?	0. No 1. Yes 88. No answer 99. Don't know	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
318	Have you ever used the Internet on any of these items: a computer, a smart phone, and/or a tablet?	0. No 1. Yes 88. No answer	_____	If 0 or 88, go to 324.
319	Have you ever accessed the Internet?	0. No 1. Yes 88. No answer	_____	If 0 or 88, go to 324.
320	How often do you access the Internet?	1. Every or almost every day 2. At least once weekly 3. Less than weekly 4. Not at all	_____	If 4, go to 324.
321	What type of information do you get from the Internet? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Email / social media 2. Current events 3. Political/religious commentary 4. Sports 5. Entertainment 6. Job advertisements 7. Other (specify): _____	_____ _____ _____	
322	Have you received health information from the Internet in the last 30 days?	0. No 1. Yes	_____	If 0, go to 324.
323	What was this information regarding? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Immunization 2. Influenza 3. Family planning 4. Handwashing/ 5. hygiene 6. Nutrition 7. High blood pressure 8. Smoking cigarettes 9. Other (specify): _____	_____ _____ _____	
324	Have you received care from a medical provider in the last 6 months?	0. No 1. Yes	_____	If 0, go to 327.
325	If yes, did you receive any counseling or instruction on how to improve/maintain your health?	0. No 1. Yes	_____	If 0, go to 327.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
326	On what topic(s) did you receive information? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Health maintenance (exercise/ nutrition) 2. Smoking cessation 3. Accident prevention 4. Stress reduction 5. Depression or other mental health issues 6. Family planning 7. Women's health 8. Child health 9. Other (specify): _____	_____ _____ _____	
327	Where do you generally get information about health? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Mother 2. Father 3. Brother/sister 4. Other family member 5. Friend 6. Religious leader/mullah 7. Village leader 8. Teacher 9. Doctor/nurse/midwife 10. Community health worker 11. Television 12. Radio 13. Internet 14. Newspaper/books 15. Telephone hotline/program 16. No answer	_____ _____ _____	
328	In the last 12 months, have you received any information about health reasons to delay marriage and/or childbearing?	0. No 1. Yes 88. No answer	_____	If 0 or 88, go to 329. If 1, go to table on next page (331).
329	In the last 12 months, have you received any information about child health, including advice about breastfeeding and other child feeding?	0. No 1. Yes 88. No answer	_____	If 0 or 88, go to 330. If 1, go to table on next page (334).

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
330	In the last 12 months, have you received any information about birth spacing or avoiding pregnancy?	0. No 1. Yes 88. No answer		If 1, go to table on next page (337). If 0 or 88, go to 340.

In the table below, please ask the question in each column and enter the number for the source reported by the participant. The participant may provide the answer for more than one question at one time. If so, please mark the answer without re-asking the question. Please do NOT read the entire list of sources but only enter the number in the question response box for the one(s) stated by the participant.

Response Choices	331. Where did you information about health reasons to delay marriage and/ or childbearing? (multiple answers allowed)	332. Which source was most convenient? (One answer only)	333. Which source was most informative/ accurate? (One answer only)	334. Where did you receive information on breastfeeding or child health?	335. Which source was most convenient? (One answer only)	336. Which source was most informative/ accurate? (One answer only)	337. Where did you receive information about birth spacing or avoiding pregnancy?	338. Which source was most convenient? (One answer only)	339. Which source was most informative/ accurate? (One answer only)
0. Did not receive information									
1. Mother									
2. Father									
3. Brother/ sister									
4. Other family member									
5. Friend									
6. Religious leader/ mullah									
7. Village leader									
8. Teacher									
9. Doctor/ nurse/ midwife									

Response Choices	331. Where did you information about health reasons to delay marriage and/ or childbearing? (multiple answers allowed)	332. Which source was most convenient? (One answer only)	333. Which source was most informative/ accurate? (One answer only)	334. Where did you receive information on breastfeeding or child health?	335. Which source was most convenient? (One answer only)	336. Which source was most informative/ accurate? (One answer only)	337. Where did you receive information about birth spacing or avoiding pregnancy?	338. Which source was most convenient? (One answer only)	339. Which source was most informative/ accurate? (One answer only)
10. Community health worker									
11. Television									
12. Radio									
13. Internet									
14. Newspaper/ books									
15. Telephone hotline/ program									
88. No answer									
99. Don't know									

STUDY STAFF: After 333, go to 329.
After 336, go to 330.
After 339, go to 340.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
340	Do you feel you need more information about health or how to maintain your health?	0. No 1. Yes 88. No answer 99. Don't know	_____	If 0, 88, or 99, skip to 342.
341	For what health areas would you want further information? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Health maintenance (exercise/ nutrition) 2. Smoking cessation 3. Accident prevention 4. Stress reduction 5. Depression or other mental health issues 6. Care during pregnancy before birth 7. Care during the birth process 8. Best care for a healthy newborn 9. Instructions on breastfeeding and best infant feeding practices 10. Information about nutrition and feeding your family 11. Information about birth spacing methods 12. Other (specify): _____	_____ _____ _____	
342	If additional information about birth spacing or protecting the health of mothers and children were available, what are the best ways to reach you? Please list the best way first, followed by the second, etc. (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Discussion with healthcare provider 2. Home visit with a community-based health worker 3. Printed information 4. Television 5. Radio 6. Send information by mobile phone in voice call 7. Telephone hotline 8. Other (specify): _____ 88. No answer	_____ _____ _____	
Now, I would like to ask you some questions about women's and children's health. Please say whether you agree or disagree with the following statements.				
400	A pregnant woman should go for regular antenatal check-ups even if she is not sick. What do you think of that statement?	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
401	Women should have at least 4 antenatal care visits during pregnancy.	1. Disagree 2. Agree 88. No answer 99. Don't know	_____	
402	In your opinion, what are some serious health problems that can occur during pregnancy that could endanger the life of a pregnant woman? I am referring to the time of pregnancy, not to the time of birth. (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Bleeding 2. Severe Headache 3. Blurred Vision 4. Convulsions 5. Swollen Hands/Face 6. Fever 7. Loss of Consciousness 8. Difficulty Breathing 9. Severe Weakness 10. Severe Abdominal Pain 11. Reduced Fetal Movement 12. Water Breaks without Labor 13. Other (specify): _____ 14. None 88. No answer 99. Don't know	_____ _____ _____	
403	In your opinion, could a woman die from any of these problems?	0. No 1. Yes 88. No answer 99. Don't know	_____	
404	Are women who become pregnant before age 18 at greater, the same, or lower risk of having complications with the pregnancy as women aged 18 to 34?	1. Greater risk 2. The same risk 3. Lower risk 88. No answer 99. Don't know	_____	
405	What could a woman do to make sure her health is safe during pregnancy? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Go for regular antenatal health checkups to a midwife or doctor 2. Take traditional medicine 3. Avoid inappropriate foods 4. Consult the religious leader/ mullah 5. Consult a dayee 6. Consult her mother-in-law/ mother 7. Other (specify): _____ 8. Nothing 88. No answer 99. Don't know	_____ _____ _____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
406	What conditions is a woman aged less than 18 years at time of delivery at greater risk for? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Pre-eclampsia/eclampsia 2. Severe headache 3. Blurred vision 4. Convulsions 5. Swollen hands/face 6. Baby cannot pass through the birth canal 7. Preterm labor/delivery 88. No answer 99. Don't know	_____ _____ _____	
407	In your opinion, where is the best place for a woman to give birth?	1. At a health facility 2. At home 3. Other (specify): _____ 88. No answer 99. Don't know	_____	
408	For what reasons do you think that is the best place for a woman to deliver a baby? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Less expensive 2. Safer 3. Better care 4. Easy to access 5. Privacy 6. Tradition 7. Other (specify): _____ 88. No answer 99. Don't know	_____ _____ _____	
409	In your opinion, what are some serious health problems that can occur during labor and childbirth that could endanger the life of a pregnant woman? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list)	1. Severe Bleeding 2. Convulsions 3. High Fever 4. Loss of Consciousness 5. Labor Lasting > 12 Hours 6. Position of the baby is "wrong" 7. Placenta Not Delivered 30 Minutes After Baby 8. Other (specify): _____ 9. None 88. No answer 99. Don't know	_____ _____ _____	
410	In your opinion, could a woman die from any of these problems?	0. No 1. Yes 88. No answer 99. Don't know	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
411	In your opinion, what are some of the things a woman and her family can do to prepare for birth? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Go to a health facility 2. Move temporarily to stay closer to a facility 3. Identify Mode of Transport to health facility 4. Save Money 5. Identify Blood Donor 6. Identify Skilled Provider 7. Other (specify): _____ 8. Nothing 88. No answer 99. Don't know	_____ _____ _____	
412	In your opinion, what is the best way to care for the umbilical cord after cutting?	1. Keep it dry 2. Use chlorhexidine to clean daily for 1 week 3. Apply something else to the remaining cord 4. Other (specify): _____ 88. No answer 99. Don't know	_____	
413	In your opinion, what is/are the best way(s) to maintain the baby's body temperature after birth? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. Put hat on baby's head 2. Keep baby well wrapped in swaddling 3. Keep baby wrapped on the mother's chest 4. Delay bathing the baby 5. Make sure the room is warm 6. Other (specify): _____ 88. No answer 99. Don't know	_____ _____ _____	
414	How long after birth should a newborn start breastfeeding?	1. Within one hour 2. Within several hours 3. Within one day 4. Within several days 5. When the white milk comes in 88. No answer 99. Don't know	_____	
415	Which is better for an infant younger than 6 months, breast milk alone or a combination of breast milk and infant formula?	1. Breast milk alone 2. Combination of breast milk and infant formula 88. No answer 99. Don't know	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
416	Until what month of age should a mother do the following things: Give her infant ONLY breast milk and NO other foods, water or infant formula?	Months in number 88. No answer 99. Don't know (Enter numbers and place 0 before the number if the response is a single number)	_____	
417	Continue breastfeeding even if providing complementary food?	Months in numbers 88. No answer 99. Don't know (Enter numbers and place 0 before the number if the response is a single number)	_____	
We will now ask you some questions about family planning. Please let me know if you need to take a break before we start the new set of questions. You are doing very well.				
500	Now I would like to ask you about a woman's risk of pregnancy. From one menstrual period to the next, have you heard if there are certain days when a woman is more likely to become pregnant when she has sexual relations?	0. No 1. Yes 88. No answer 99. Don't know	_____	If 0, 88, or 99, go to 502.
501	Is this time just before her period begins, during her period, right after her period has ended, or halfway between two periods?	1. Just before her period 2. During her period 3. Right after her period has ended 4. Halfway between two periods 88. No answer 99. Don't know	_____	
502	Have you ever heard of ways or methods that a couple can use to delay or avoid a pregnancy?	0. No 1. Yes 88. No answer	_____	If 0 or 88, go to 504.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
503	Which ways or methods have you heard of? (INTERVIEWER: Please circle all choices mentioned by the participant; do NOT read the list. More than one answer is acceptable here.)	1. IUD/ loop 2. Condoms 3. Oral contraceptives 4. Injectable contraceptives 5. Implant 6. Female sterilization 7. Male sterilization 8. Rhythm method/standard days 9. Withdrawal 10. Lactational amenorrhea 11. Emergency contraception	_____ _____ _____	
504	For how many months after a baby is born will exclusive breastfeeding (meaning breast milk only is given to the baby, no solid food or other liquids) be effective for preventing pregnancy?	_____ months 88. No answer 99. Don't know	_____	
Please indicate whether you agree with the following statements regarding family planning:				
505	Withdrawal (el azl) is a highly effective method for preventing pregnancy	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
506	Young women should not use family planning methods because it may create problems getting pregnant later	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
507	The IUD or loop can prevent pregnancy for up to 10 years.	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
508	Irregular periods or bleeding between periods while using the injection or implant will usually resolve on its own.	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
Attitudes, Care Utilization, and Decision-making				
600	Have you been to a health facility for care for yourself in the last three months?	0. No 1. Yes 88. No answer	_____	

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
601	When you have a question about a health issue, what source do you usually consult for information? Please list the sources in the order of you would go to first, then second, etc.	1. Mother 2. Father 3. Brother/sister 4. Other family member 5. Friend 6. Religious leader 7. Internet 8. Book/magazine 9. Doctor/midwife 10. Community health worker 11. Hotline/Call center 12. Other (specify): _____ 13. No one 88. No answer	_____	
602	When you have a question about reproductive health issues, what source do you usually consult for information? Please list the sources in the order of you would go to first, then second, etc.	1. Mother 2. Father 3. Friend 4. Teacher 5. Internet 6. Book/magazine 7. Doctor/midwife 8. Community health worker 9. Hotline/Call center 10. Other (specify): _____	_____	
603	If there were a free mobile phone based information project for reproductive health, how likely would you be to use it?	1. Very likely 2. Somewhat likely 3. Neither likely nor unlikely 4. Somewhat unlikely 5. Very unlikely/wouldn't use	_____	
604	If you used this mobile phone program for advice on family planning and general health, would you prefer to hear a recorded message or speak to a live person?	1. Hear a recorded message 2. Speak to a live person 99. Don't know	_____	

I will now read you some statements about family decision-making that involve female members of your family. We are asking these questions to better understand what health information men provide to their wives and how much couples talk about health issues and decisions. These questions may be sensitive and you are welcome to ask me about why these questions are here. Please remember you may decline to answer a question at any time. If you agree, can we proceed? (If agrees, then proceed with next statement). Please tell me if you agree or disagree with each one.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
700	In your opinion, is a husband justified in hitting or beating his wife if: she goes out without telling him?	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
701	If she neglects the children?	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
702	If she argues with him?	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
703	If she burns the food?	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
704	If she refuses to have sex with him?	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
705	Contraception is a woman's business and a man should not have to worry about it.	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
706	Women who use contraception may become promiscuous.	1. Agree 2. Disagree 88. No answer 99. Don't know	_____	
Now I would like to ask about your own actual situation in terms of marriage.				
707	Are you married?	0. No 1. Yes	_____	If 1, go to 708 and mention "spouse"; if 0, go to 710.
708	How old were you when you married?	[Age in years]	_____	
709	How long had you known your (current/last) spouse before you married?	1. Met on the wedding day 2. Less than one month 3. 1 month to less than 1 year 4. 1 year or more 5. Other (specify): _____	_____	Go to 712.
710	Are you engaged?	0. No 1. Yes	_____	If 1, go to 711 and mention "fiancée". If 0, go to 800.

For interviewer completion only

#	Question	Response Choices	Entry	Skip Pattern
711	How old were you when you got engaged?	[Age in years]	_____	
712	Who chose your spouse/ fiancee?	1. Respondent chose 2. Respondent and spouse/ fiancee chose each other 3. Respondent's family chose 4. Spouse's family chose	_____	If 1 or 2, go to 800.
713	When your spouse/fiancee was being chosen for you, were you asked whether you wanted to marry him/her of not?	0. No 1. Yes 88. No answer	_____	

Now I would like to read some statements for you about your attitude towards marriage in general. (Even if you were married a certain way/age, you may have a different opinion than what happened to you). You can respond with: strongly disagree (SDA), disagree (DA), neither disagree or agree (NDA/A), agree (A), and strongly agree (SA)

		SDA	DA	NDA/A	A	SA	Response
800	*It is better marrying at age 16 than at age 24 years*	05	04	03	02	01	
801	*Marriage should be before first menstruation*	05	04	03	02	01	
802	*The ideal age at marriage is less than 24 years old*	05	04	03	02	01	
803	*The ideal age at marriage is more than 24 years old*	05	04	03	02	01	
804	*Women should control when they marry*	05	04	03	02	01	
805	*Men should control when they marry*	05	04	03	02	01	
806	*It is better for young people to choose who they marry*	05	04	03	02	01	
807	*It is better for parents to choose who their children marry*	05	04	03	02	01	
808	*Parental consent (for marrying) is required*	05	04	03	02	01	
809	*Parents should have a young person's consent is required before marrying*	05	04	03	02	01	
810	*Love marriage is good*	05	04	03	02	01	
811	*It is better to know your future husband/wife before you marry*	05	04	03	02	01	
812	*It is acceptable to meet him/her on the day of the wedding*	05	04	03	02	01	

Now I would like to read some statements for you. You can respond with: strongly disagree (SDA), disagree (DA), neither disagree or agree (NDA/A), agree (A), and strongly agree (SA)

		SDA	DA	NDA/A	A	SA	Response
900	*Husbands and wives in my community use family planning to space between births*	05	04	03	02	01	
901	*Women in my community get care for their pregnancies from health providers before delivery.*	05	04	03	02	01	

		SDA	DA	NDA/A	A	SA	Response
902	*Women in my community give birth at health facilities.*	05	04	03	02	01	
903	*Women in my community go to health facility/ talk to health workers about family planning methods*	05	04	03	02	01	
904	*Men in my community go to health facility/ talk to health workers about family planning methods*	05	04	03	02	01	
905	*Men in my community go to health facility/ talk to health workers about antenatal care and birth planning*	05	04	03	02	01	
906	*People in my community are supportive regarding family planning use*	05	04	03	02	01	
907	*People in my community are supportive regarding delivering in a health facility*	05	04	03	02	01	
908	*Men in my community are involved family planning*	05	04	03	02	01	
909	*Men in my community are involved birth preparedness planning*	05	04	03	02	01	
910	*I believe that frequent childbearing with short spacing between births is harmful to the health of the mother*	05	04	03	02	01	
911	*I believe that early (before age 18) childbearing is harmful to the health of the mother.*	05	04	03	02	01	
912	*I believe that using family planning methods to space children is safe*	05	04	03	02	01	
913	*Most family planning methods can removed anytime/stop anytime whenever you want to be pregnant*	05	04	03	02	01	
914	*Going to at least 4 ANC visits can help women have healthier babies*	05	04	03	02	01	
915	*Families are more prepared for having babies if husbands are involved in their wives' family planning use*	05	04	03	02	01	
916	*In case a woman experiences complications during delivery, she is more likely to get the help she needs at a health facility than if she gives birth at home*	05	04	03	02	01	
917	*Families are more likely to have healthy babies and mothers if husbands are involved in their wives' birth preparedness planning*	05	04	03	02	01	
918	*Families who use family planning to space their pregnancies have a better future than families who do not use family planning*	05	04	03	02	01	
919	*It is difficult for women to get family planning methods*	05	04	03	02	01	
920	*It is difficult for women to go to at least 4 antenatal visits during pregnancy*	05	04	03	02	01	
921	*It is difficult for pregnant women to access healthy foods.*	05	04	03	02	01	

		SDA	DA	NDA/A	A	SA	Response
922	*It is difficult for women to be able to give birth in health facilities*	05	04	03	02	01	
923	*It is difficult for infants to get care in health facilities*	05	04	03	02	01	
924	*My community wouldn't think it is appropriate for husbands to be involved in their wives' use of family planning methods*	05	04	03	02	01	
925	*My community wouldn't think it is appropriate for husbands to be involved in their wives pregnancies*	05	04	03	02	01	

926	End time of interview	Hours written in 24 hour clock, for example 8 pm = 20:00 hours	_____ hrs: _____ min	Thank the participant for their time.

Annex 3:
QUAL INSTRUMENTS

USAID/HEMAYAT PROJECT
Communication Assessment FGD Moderator's Guide (Men)

Instructions

This guide is meant to provide structure to the focus group exercise. The exercise itself should be conducted in a natural, conversational manner. The facilitator's role is to set boundaries for the discussion and assure participation from all members present, especially those holding a minority viewpoint. The questions below are a list of topics to be discussed in the focus group in order to meet the project's goals. The questions are not meant to be read, but serve as a reminder to the facilitator of areas in which discussion needs to be guided. After a story is told or a statement made, the facilitator should probe for further, related details, particularly from those who have not spoken, by asking: "Any other ideas?" or "I have not heard from you yet – what is your experience related to what he/she just said?" At the end of discussion of a particular topic, the facilitator should get an idea of the group consensus by asking: "Is this a typical experience for the rest of you?" "Does anyone have another example or a counter-example?"

Setting
Have the group sit in a circle. Have refreshments for when people first arrive (while waiting for everyone). Have your audio recording equipment ready before anyone arrives. Feel free to chat and set a positive tone while waiting. Have everyone seated before beginning.

I. Welcome and Introductions

(A) Good morning/afternoon/evening. My name is _____ and I work for _____. You were specially chosen for the opportunity to participate in this discussion. Our discussion will ask for your thoughts regarding experiences and preferences for health communications, especially that about mothers and children. We would like to learn more about your perspectives on current health messaging and how it relates to family health and life needs for you or people in your community.

As part of our study, we have asked you here to discuss your ideas, insights, and suggestions. We will talk for about 1 hour about the questions, and then I will ask everyone, for not more than 30 minutes, what you think about the questions.

I will be helping the discussion along, keeping everyone focused, and making sure that everyone has a chance to speak. This is _____. He/she will be keeping notes during the discussion to track important ideas. He/she will not record any names. We are also audio-recording the discussion to make sure we do not miss any information. The digital files of the recordings will be transcribed and then destroyed. We will not keep anyone's name or other identifying information.

(B) We are here to learn from you. Please let us know your opinion about the topics discussed. There are no right answers. Please talk freely and openly.

(C) Now let's each briefly introduce ourselves. You can use your number if you prefer not to state your name, and tell a sentence or two about ourselves.

(D) Let me go over some ground rules for the discussion and then we will begin. Please do not interrupt when someone is speaking and let everyone have a chance to speak. Everything you say here is confidential and we ask all the participants to respect each other's confidentiality once the focus group is over.

Instructions

Now begin with the first question. Probe to try to have participants give specific details and example and encourage commentary from all participants. Probes are optional but should be used to explore issues mentioned the first few times and for new ideas that arise. Ask for clarification when necessary. Try to touch on all the topics below, but if they naturally arise in a different order during the discussion, that is great. Do not read these questions as if conducting a survey, instead try for rich, deep detail, examples, and insight about each of the topics. If you are stuck or things are quiet, you can also ask the reporter for a topic or idea that has been mentioned, but not fully explored. Please make sure the session recorder writes down the number/name of each person in the order they are speaking.

II. Theme I – Sources of Health Information

(A) What would you say are the most important health issues today for families like yours? Why are these important?

Probes:

- What about health issues for women? What makes this issue so important? Can we list the issues by level of importance, starting with the most important? **[Session recorder to write issues on flip chart for group]**
- What about health issues for babies or children? What makes this issue so important? Can we list the issues by level of importance, starting with the most important? **[Session recorder to write issues on flip chart for group]**

(B) What other health topics do you hear being discussed?

(C) When people talk about these health issues, where do they get their information?

Probes:

- What have you heard about on the radio?
- What about on television?
- From which specific people or groups do people get health information?
- What about from health providers?
- Community health workers?
- Religious leaders?
- Mobile phone?
- Internet?

(D) Of the different sources of information we just discussed, which sources do men in your community trust the most for health information, and why?

Probes:

- Probe on the various channels mentioned from the list above
- Which channel is trusted most for information about mothers' health? Why?
- Which channel is trusted most for information about babies'/children's health? Why?
- Which sources of information are the least trusted for health information?

(E) What health information that men in your community have received was the most memorable? What made it memorable?

(F) Which maternal or child health issues do men in your community wish they could receive more information about?

Probes:

- What about keeping mothers and babies safe?
- What question do men wish they could get answered?

(G) What kinds of challenges do men face getting information or answers to health questions they might have?

Probes:

- What about information on the health of your wives or children?

III. Theme 2 – Healthcare Access

(A) Now I'd like to talk a bit about how families in your community get healthcare when they need it. When families have a health issue like the ones we just discussed, how do they usually handle it?

Probes:

- Where do men seek health care/ information? Can you name some of these places?
- How would you describe these places?
- How comfortable are men with these places? Why are they comfortable or uncomfortable?
- How do the health care providers in these places behave towards men?
- How do men feel about speaking to doctors or other health care providers themselves when they have an issue?
- How do men feel about speaking to a health care provider if their wife or child has a healthcare issue?

(B) What challenges might people face going to see a doctor?

Probes:

- What challenges are present for seeking maternal health care/ health care for wives?
- What challenges are present for seeking health care for babies or young children?

(C) What communication and health care programs are available that help people to address their health concerns? An example might be National Immunization Days, cooking demonstrations for nutritious food, or community midwife visits. Which are the most important/useful to you and your families?

Probes:

- What do men in your community like best about these programs?
- What do men in your community not like about these programs?

(D) What kinds of programs or services are still needed so that men in your community can better protect their family's health?

IV. Theme 3 – Decision-making for Health Seeking

(A) How are health decisions made in most households in your community? If someone has a health problem, how does the family decide what to do?

Probes:

- Who makes the final decision?
- Who else does a husband consult with before he decides what to do?

(B) What kinds of household decisions do men typically discuss with their wives? What kinds of health decisions do men typically discuss with their wives?

Probes:

- How are decisions made about how to manage a delivery?
- How are decisions made about whether to have a doctor or midwife for a delivery? With whom is the issue discussed before a decision is made? What factors influence the decision?
- How are decisions made for seeking care when a child is ill? With whom is the issue discussed before a decision is made? What factors influence the decision?

- How are decisions made with regard to birth spacing method use? With whom is the issue discussed before a decision is made? What factors influence the decision?

(C) Which person in the family is seen as a reliable source of healthcare information? What makes them the most reliable source?

V. Theme 4 – Media Reach

(A) I'd also like to talk for a few minutes about how we might best reach men like you with new information about protecting your family's health. How would men in your community like to receive information about the health issues we discussed before, about protecting the health of wives and children?

Probes:

- What would be the advantages of receiving health information this way?
- What might be men's concerns?
- How much would people trust information about mother and child health coming from this source(s)?
- Is privacy a concern for message delivery?
- Is it better to deliver messages to groups or to men individually?

(B) I would like to tell you a story and then ask questions about what you think. We are considering a program to deliver information to families through their mobile phones containing important information about the health of women and children and what people can do to keep their families healthy. Men and women would receive regular messages, either by calling a number or being called/ receiving a voice SMS, which means you are called and hear a recorded message, and would listen to a voice read the information. How would men feel about receiving information this way?

Probes:

- How many people in your community have their own mobile phone? How many have access to a mobile phone?
- What do men in your community use a mobile phone to do? [Probe: Make business calls, call/ text friends, call helplines, access the internet, etc.]
- What happens to messages sent or accessed through mobile phones?
- What would be the advantages of receiving health information over a mobile phone?
- What concerns would men have about receiving information this way? (Trust? Privacy? Concerns about operating the phone correctly? Other?)
- Would people listen to these messages?
- Would men allow their wives to receive messages this way?
- What would make the messages appealing?

(C) How would men feel if they were able to call a telephone number to get information and answers to specific health questions they had?

Probes:

- What might make it easier for people to call?
- What might make it harder?

(D) If this service was available but men in your community had to pay, how would people be willing to pay?

(E) How easy is it for men in your community to get access to a phone and enough privacy to listen to messages?

Probes:
- Is it different if you are married/unmarried?
- What about urban/rural?
- How easy is it for a woman to use a phone privately?

(F) We are also interested in using mobile phones to send information to women about protecting their health and their children's health. How would men in your community feel about this?
Probes:
- What might be the good things about this?
- What worries would men have?
- What could we do to make it easier for men to allow their wives to receive such messages?

VI. Closing (5 minutes)

When the time is almost finished, summarize what the participants have discussed and ask them if they want to add anything else to the discussion. Get a sense of consensus for each of the ideas.
End by thanking the group.

If you have identified any immediate need for healthcare access among a member of the group of FGD participants, have a member of the research team meet privately with this individual to answer any questions they may have and to provide assistance with referral as appropriate.

VII. Additional Instructions for the Note Taker

Please use the note-taker form that should have been included with this document. Consult the attached files for a sample of using the note-taker form.

Speaker identification
It can be very hard to identify a speaker in a tape of a focus group. Ask the session recorder to write the number or name used by each speaker in the order of speaking. The number in the transcript will enable us to link ideas from the focus group to the demographics of the speaker as well as detect dominant and non-dominant speakers.

Have a Note taker
The role of the note taker is to record the main points of the discussion, to indicate things (either spoken or unspoken) that will not be shown on the focus group transcript and impacted the conversation (non-verbal actions or issues that disrupted the flow of conversation), and to track the order in which people provide commentary. For example, the note taker may notice that as one participant speaks, the others nod in agreement. This should be noted. They should also note when people disagree, feel uncomfortable with a topic or get excited.

Note Taking Strategies
Be sure that each note contains a brief summary of the topic being discussed, a note about who is speaking (in order), and an assessment of main themes and non-verbal communication. An example would look like this: #4, if it lasts just 3 days, I'm alright but if it goes longer I feel sick, some nod in agreement. You can also note the general feeling of the group. For example, when asked about a program to deliver messages by mobile phone, group became excited and very interested. You can also note observations that you might have: participants seem to follow the lead of the oldest member when discussing mobile phone messaging.

Don't Note Everything
Only make a note when there is some reaction from the group, the "feeling" in the room changes, or you have an observation to make.

Type the Notes
Notes should be typed and attached to the transcript of the interview. Please keep in mind that notes are part of the data that will be analyzed. Be sure to make sure the notes are understandable and complete. Notes should be typed up as soon as possible after the FGD so that all the details will be remembered. Plan time (at least several hours) for doing this.

USAID/HEMAYAT PROJECT
Communication Assessment FGD Moderator's Guide (Youth)

Instructions

This guide is meant to provide structure to the focus group exercise. The exercise itself should be conducted in a natural, conversational manner. The facilitator's role is to set boundaries for the discussion and assure participation from all members present, especially those holding a minority viewpoint. The questions below are a list of topics to be discussed in the focus group in order to meet the project's goals. The questions are not meant to be read, but serve as a reminder to the facilitator of areas in which discussion needs to be guided. After a story is told or a statement made, the facilitator should probe for further, related details, particularly from those who have not spoken, by asking: "Any other ideas?" or "I have not heard from you yet – what is your experience related to what he/she just said?" At the end of discussion of a particular topic, the facilitator should get an idea of the group consensus by asking: "Is this a typical experience for the rest of you?" "Does anyone have another example or a counterexample?"

Setting
Have the group sit in a circle. Have refreshments for when people first arrive (while waiting for everyone). Have your audio recording equipment ready before anyone arrives. Feel free to chat and set a positive tone while waiting. Have everyone seated before beginning.

I. Welcome and Introductions (XX minutes)

(A) Good morning/afternoon/evening. My name is _____ and I work for _____. You were specially chosen for the opportunity to participate in this discussion. Our discussion will ask for your thoughts regarding experiences and preferences for health communications, especially that about mothers and children. We would like to learn more about your perspectives on current health messaging and how it relates to health and life needs for you or young people in your community.

As part of our study, we have asked you here to discuss your ideas, insights, and suggestions. We will talk for about one hour about the questions, and then I will ask everyone, for not more than 30 minutes, what you think about the questions.

I will be helping the discussion along, keeping everyone focused, and making sure that everyone has a chance to speak. This is _____ . He/she will be keeping notes during the discussion to track important ideas. He/she will not record any names. We are also audio-recording the discussion to make sure we do not miss any information. The digital files of the recordings will be transcribed and then destroyed. We will not keep anyone's name or other identifying information.

(B) We are here to learn from you. Please let us know your opinion about the topics discussed. There are no right answers. Please talk freely and openly.

(C) Now let's each briefly introduce ourselves – you can use your number if you prefer not to state your name - and tell a sentence or two about ourselves.

(D) Let me go over some ground rules for the discussion and then we will begin. Please do not interrupt when someone is speaking and let everyone have a chance to speak. Everything you say here is confidential and we ask all the participants to respect each other's confidentiality once the focus group is over.

Instructions

Now begin with the first question. Probe to try to have participants give specific details and example and encourage commentary from all participants. Probes are optional but should be used to explore issues mentioned the first few times and for new ideas that arise. Ask for clarification when necessary. Try to touch on all the topics below, but if they naturally arise in a different order during the discussion, that is great. Do not read these questions as if conducting a survey, instead try for rich, deep detail, examples, and insight about each of the topics. If you are stuck or things are quiet, you can also ask the reporter for a topic or idea that has been mentioned, but not fully explored. Please make sure the session recorder writes down the number/name of each person in the order they are speaking.

II. Theme I – Sources of Health Information

(A) What would you say are the most important health issues today for young people in your community? What makes these issues important?

Probes:

- What about health issues for women? What makes these issues important? Can we list the issues by level of importance, starting with the most important? **[Session recorder to write issues on flip chart for group]**
- What about health issues for babies or children? What makes these issues important? Can we list the issues by level of importance, starting with the most important? **[Session recorder to write issues on flip chart for group]**

(B) What other health topics have young people in your community heard being discussed?

(C) When people talk about these health issues, where do they get their information?

Probes:

- What have you heard about on the radio?
- What about on television?
- From which specific people or groups do people get health information?
- What about from health providers?
- Community health workers?
- Religious leaders?
- Mobile phone?
- Internet?

(D) Of the different sources of information we just discussed, which sources do young people in your community trust the most for health information, and why?

Probes:

- Probe on the various channels mentioned from the list above
- Which channel is trusted most for information about mothers' health? What makes this channel trustworthy?
- Which channel is trusted most for information about babies'/children's health? What makes this channel trustworthy?
- Which sources of information are the least trusted for health information?

(E) What health information received by young people in your community was the most memorable? What made it memorable?

(F) Which maternal or child health issues do young people in your community wish they could receive more information about?

Probe:

- What about keeping mothers and babies safe? What questions do young people want to get answered?

(G) What kinds of challenges do young people face getting information or answers to health questions they might have?

Probe:

- What about information on where to get health advice or care?

III. Theme 2 – Healthcare Access

(A) Now I'd like to talk a bit about how young people in your community get healthcare when they need it. When young people in your community have a health issue like the ones we just discussed, how do they usually handle it?

Probes:

- Where do young people seek health care/ information? What are some of these places?
- How would you describe these places?
- How comfortable are young people with these places? What makes them comfortable/ uncomfortable?
- How do the health care providers behave at these places toward young people?

(B) What challenges might young adults face going to see a doctor?

Probes:

- What challenges are present for seeking maternal health care/ reproductive health care?
- What is the behavior of health care providers typically like with young adults/youth?
- Do health care facilities respect the privacy of young people? Respect their right to make decisions?
- Do young people face judgmental attitudes at health facilities?

(C) What communication and health care programs are available which help young people to address their health concerns? An example might be National Immunization Days, cooking demonstrations for nutritious food, or community midwife visits. Which are the most important/useful to young people in your community?

Probes:

- What do young people like best about these programs?
- What do young people not like about these programs?
- [For GIHS FGD groups: As future health care providers, what ways are most effective to reach young people?
- How should messaging be different for the adolescent and young adult population?]

(D) What kinds of programs or services for young adults in your community are still needed so that they can better protect their health?

IV. Theme 3 – Decision-making for Health Seeking

(A) In your community, who do young people consult to obtain needed health services?

Probes:

- Who makes the final decision?
- What factors influence the decision to seek care?

(B) What health topics do you/your friends feel comfortable discussing with a health provider?
Probes:
- What topics do you/your friends feel comfortable discussing with a health care provider?
- What topics do you/your friends not feel comfortable discussing with a health care provider but about which you wish you had more information?

(C) Which person in the family is seen as a reliable source of healthcare information? Why?

V. Theme 4 – Media Reach

(A) I'd also like to talk for a few minutes about how we might best reach young people like you with new information about protecting their health. How would young adults in your community like to receive information about the health issues we discussed before, about reproductive and family health?
Probes:
- What would be the advantages of receiving health information this way?
- What might be young people's concerns?
- How much would young people trust information about reproductive health coming from this source(s)?
- Is privacy a concern for message delivery?
- Is it better to deliver messages to groups or to young people individually?

(B) I would like to tell you a story and then ask questions about what you think. We are considering sending regular voice recordings to people's mobile phones containing important information about reproductive health and other health concerns of young people and what people can do to keep themselves and their families healthy. This type of program may be publicized through radio or television with calling a short code to hear a recording or speak to a live agent about a topic in which they are interested or started as a subscription through a community health worker or other health provider in your community. Are messages sent or accessed through mobile phone likely to be heard?
Probes:
- How many young people in your community have their own mobile phone? How many have access to a mobile phone?
- What do young people in your community use their mobile phone to do? [Probe: Play games, call/text friends, call helplines, access the internet, etc.]
- What happens to messages sent or accessed through mobile phones?
- What would be the advantages of receiving health information over a mobile phone?
- What concerns would young adults have about receiving information this way? (Trust? Privacy? Concerns about operating the phone correctly? Other?)
- Are these concerns different for young men and young women? How?
- Would young adults listen to these messages?
- What would make the messages appealing?

(C) How would young adults feel if they were able to call a telephone number to get information and answers to specific health questions they had?
Probes:
- What might make it easier for young adults to call?
- What might make it harder?

(D) Do you think young people would prefer to listen to a recorded message and follow up with a health provider if they had questions or speak to a live agent? Why or why not?

Probes:
- What topics would young people prefer to hear a recording for?
- What topics would young people prefer to speak to a live agent about?

(E) If this service was available but young adults had to pay, how much would young people be willing to pay?

(F) How easy is it for young people to get access to a phone and enough privacy to listen to messages?
Probes:
- Is it different if a young person is married/unmarried?
- What about urban/rural?
- How easy is it for a young woman to use a phone privately?
- Would families in your community allow the young women in their homes to listen to health messages sent by mobile phone?

VI. Closing

When the time is almost finished, summarize what the participants have discussed and ask them if they want to add anything else to the discussion. Get a sense of consensus for each of the ideas.

End by thanking the group.

If you have identified any immediate need for healthcare access among a member of the group of FGD participants, have a member of the research team meet privately with this individual to answer any questions they may have and to provide assistance with referral as appropriate.

VII. Additional Instructions for the Note Taker

Please use the note-taker form that should have been included with this document. Consult the attached files for a sample of using the note-taker form.

Speaker identification
It can be very hard to identify a speaker in a tape of a focus group. Ask the session recorder to write the number or name used by each speaker in the order of speaking. This will make it possible to link ideas from the focus group to the demographics of the speaker as well as detect dominant and non-dominant speakers.

Have a Note taker
The role of the note taker is to record the main points of the discussion, to indicate things (either spoken or unspoken) that will not be shown on the focus group transcript and impacted the conversation (non-verbal actions or issues that disrupted the flow of conversation), and to track the order in which people provide commentary. For example, the note taker may notice that as one participant speaks, the others nod in agreement. This should be noted. They should also note when people disagree, feel uncomfortable with a topic or get excited.

Note Taking Strategies
Be sure that each note contains a brief summary of the topic being discussed, a note about who is speaking (in order), and an assessment of main themes and non-verbal communication. An example would look like this: #4, if it lasts just 3 days, I'm alright but if it goes longer I feel sick, some nod in agreement. You

can also note the general feeling of the group. For example, when asked about aa program to deliver messages by mobile phone, group became excited and very interested. You can also note observations that you might have: participants seem to follow the lead of the oldest member when discussing mobile phone messaging.

Don't Note Everything
Only make a note when there is some reaction from the group, the "feeling" in the room changes, or you have an observation to make.

Type the Notes
Notes should be typed and attached to the transcript of the interview. Please keep in mind that notes are part of the data that will be analyzed. Be sure to make sure the notes are understandable and complete. Notes should be typed up as soon as possible after the FGD so that all the details will be remembered. Plan time (at least several hours) for doing this.

USAID/HEMAYAT PROJECT
Communication Assessment FGD Moderator's Guide (Men)

Instructions

This guide is meant to provide structure to the focus group exercise. The exercise itself should be conducted in a natural, conversational manner. The facilitator's role is to set boundaries for the discussion and assure participation from all members present, especially those holding a minority viewpoint. The questions below are a list of topics to be discussed in the focus group in order to meet the project's goals. The questions are not meant to be read, but serve as a reminder to the facilitator of areas in which discussion needs to be guided. After a story is told or a statement made, the facilitator should probe for further, related details, particularly from those who have not spoken, by asking: "Any other ideas?" or "I have not heard from you yet – what is your experience related to what he/she just said?" At the end of discussion of a particular topic, the facilitator should get an idea of the group consensus by asking: "Is this a typical experience for the rest of you?" "Does anyone have another example or a counter-example?"

Setting
Have the group sit in a circle. Have refreshments for when people first arrive (while waiting for everyone). Have your audio recording equipment ready before anyone arrives. Feel free to chat and set a positive tone while waiting. Have everyone seated before beginning.

I. Welcome and Introductions

(A) Good morning/afternoon/evening. My name is _____ and I work for _____. You were specially chosen for the opportunity to participate in this discussion. Our discussion will ask for your thoughts regarding experiences and preferences for health communications, especially that about mothers and children. We would like to learn more about your perspectives on current health messaging and how it relates to family health and life needs for you or people in your community.

As part of our study, we have asked you here to discuss your ideas, insights, and suggestions. We will talk for about 1 hour about the questions, and then I will ask everyone, for not more than 30 minutes, what you think about the questions.

I will be helping the discussion along, keeping everyone focused, and making sure that everyone has a chance to speak. This is _____. He/she will be keeping notes during the discussion to track important ideas. He/she will not record any names. We are also audio-recording the discussion to make sure we do not miss any information. The digital files of the recordings will be transcribed and then destroyed. We will not keep anyone's name or other identifying information.

(B) We are here to learn from you. Please let us know your opinion about the topics discussed. There are no right answers. Please talk freely and openly.

(C) Now let's each briefly introduce ourselves – you can use your number if you prefer not to state your name - and tell a sentence or two about ourselves.

(D) Let me go over some ground rules for the discussion and then we will begin. Please do not interrupt when someone is speaking and let everyone have a chance to speak. Everything you say here is confidential and we ask all the participants to respect each other's confidentiality once the focus group is over.

Instructions
Now begin with the first question. Probe to try to have participants give specific details and example and encourage commentary from all participants. Probes are optional but should be used to explore issues mentioned the first few times and for new ideas that arise. Ask for clarification when necessary. Try to touch on all the topics below, but if they naturally arise in a different order during the discussion, that is great. Do not read these questions as if conducting a survey, instead try for rich, deep detail, examples, and insight about each of the topics. If you are stuck or things are quiet, you can also ask the reporter for a topic or idea that has been mentioned, but not fully explored. Please make sure the session recorder writes down the number/name of each person in the order they are speaking.

II. Theme I – Sources of Health Information

(A) What would you say are the most important health issues today for families like yours? Why are these important?
Probes:
- What about health issues for women? What makes this issue so important? Can we list the issues by level of importance, starting with the most important? **[Session recorder to write issues on flip chart for group]**
- What about health issues for babies or children? What makes this issue so important? Can we list the issues by level of importance, starting with the most important? **[Session recorder to write issues on flip chart for group]**

(B) What other health topics do you hear being discussed?

(C) When people talk about these health issues, where do they get their information?
Probes:
- What have you heard about on the radio?
- What about on television?
- From which specific people or groups do people get health information?
- What about from health providers?
- Community health workers?
- Religious leaders?
- Mobile phone?
- Internet?

(D) Of the different sources of information we just discussed, which sources do men in your community trust the most for health information, and why?
Probes:
- Probe on the various channels mentioned from the list above
- Which channel is trusted most for information about mothers' health? Why?
- Which channel is trusted most for information about babies'/children's health? Why?
- Which sources of information are the least trusted for health information?

(E) What health information that men in your community have received was the most memorable? What made it memorable?

(F) Which maternal or child health issues do men in your community wish they could receive more information about?

Probes:

- What about keeping mothers and babies safe? What question do men wish they could get answered?

(G) What kinds of challenges do men face getting information or answers to health questions they might have?

Probes:

- What about information on the health of your wives or children?

III. Theme 2 – Healthcare Access

(A) Now I'd like to talk a bit about how families in your community get healthcare when they need it. When families have a health issue like the ones we just discussed, how do they usually handle it?

Probes:

- Where do men seek health care/ information? Can you name some of these places?
- How would you describe these places?
- How comfortable are men with these places? Why are they comfortable or uncomfortable?
- How do the health care providers in these places behave towards men?
- How do men feel about speaking to doctors or other health care providers themselves when they have an issue?
- How do men feel about speaking to a health care provider if their wife or child has a healthcare issue?

(B) What challenges might people face going to see a doctor?

Probes:

- What challenges are present for seeking maternal health care/ health care for wives?
- What challenges are present for seeking health care for babies or young children?

(C) What communication and health care programs are available that help people to address their health concerns? An example might be National Immunization Days, cooking demonstrations for nutritious food, or community midwife visits. Which are the most important/useful to you and your families?

Probes:

- What do men in your community like best about these programs?
- What do men in your community not like about these programs?

(D) What kinds of programs or services are still needed so that men in your community can better protect their family's health?

IV. Theme 3 – Decision-making for Health Seeking

(A) How are health decisions made in most households in your community? If someone has a health problem, how does the family decide what to do?

Probes:

- Who makes the final decision?
- Who else does a husband consult with before he decides what to do?

(B) What kinds of household decisions do men typically discuss with their wives? What kinds of health decisions do men typically discuss with their wives?

Probes:

- How are decisions made about how to manage a delivery?
- How are decisions made about whether to have a doctor or midwife for a delivery? With whom is the issue discussed before a decision is made? What factors influence the decision?
- How are decisions made for seeking care when a child is ill? With whom is the issue discussed before a decision is made? What factors influence the decision?
- How are decisions made with regard to birth spacing method use? With whom is the issue discussed before a decision is made? What factors influence the decision?

(C) Which person in the family is seen as a reliable source of healthcare information? What makes them the most reliable source?

V. Theme 4 – Media Reach

(A) I'd also like to talk for a few minutes about how we might best reach men like you with new information about protecting your family's health. How would men in your community like to receive information about the health issues we discussed before, about protecting the health of wives and children?

Probes:

- What would be the advantages of receiving health information this way?
- What might be men's concerns?
- How much would people trust information about mother and child health coming from this source(s)?
- Is privacy a concern for message delivery?
- Is it better to deliver messages to groups or to men individually?

(B) I would like to tell you a story and then ask questions about what you think. We are considering a program to deliver information to families through their mobile phones containing important information about the health of women and children and what people can do to keep their families healthy. Men and women would receive regular messages, either by calling a number or being called/ receiving a voice SMS, which means you are called and hear a recorded message, and would listen to a voice read the information. How would men feel about receiving information this way?

Probes:

- How many people in your community have their own mobile phone? How many have access to a mobile phone?
- What do men in your community use a mobile phone to do? [Probe: Make business calls, call/ text friends, call helplines, access the internet, etc.]
- What happens to messages sent or accessed through mobile phones?
- What would be the advantages of receiving health information over a mobile phone?
- What concerns would men have about receiving information this way? (Trust? Privacy? Concerns about operating the phone correctly? Other?)
- Would people listen to these messages?
- Would men allow their wives to receive messages this way?
- What would make the messages appealing?

(C) How would men feel if they were able to call a telephone number to get information and answers to specific health questions they had?

Probes:

- What might make it easier for people to call?
- What might make it harder?

(D) If this service was available but men in your community had to pay, how would people be willing to pay?

(E) How easy is it for men in your community to get access to a phone and enough privacy to listen to messages?
Probes:
- Is it different if you are married/unmarried?
- What about urban/rural?
- How easy is it for a woman to use a phone privately?

(F) We are also interested in using mobile phones to send information to women about protecting their health and their children's health. How would men in your community feel about this?
Probes:
- What might be the good things about this?
- What worries would men have?
- What could we do to make it easier for men to allow their wives to receive such messages?

VI. Closing (5 minutes)

(A) When the time is almost finished, summarize what the participants have discussed and ask them if they want to add anything else to the discussion. Get a sense of consensus for each of the ideas.

(B) End by thanking the group.

(C) If you have identified any immediate need for healthcare access among a member of the group of FGD participants, have a member of the research team meet privately with this individual to answer any questions they may have and to provide assistance with referral as appropriate.

VII. Additional Instructions for the Note Taker

Please use the note-taker form that should have been included with this document. Consult the attached files for a sample of using the note-taker form.

Speaker identification
It can be very hard to identify a speaker in a tape of a focus group. Ask the session recorder to write the number or name used by each speaker in the order of speaking. The number in the transcript will enable us to link ideas from the focus group to the demographics of the speaker as well as detect dominant and non-dominant speakers.

Have a Note taker
The role of the note taker is to record the main points of the discussion, to indicate things (either spoken or unspoken) that will not be shown on the focus group transcript and impacted the conversation (non-verbal actions or issues that disrupted the flow of conversation), and to track the order in which people provide commentary. For example, the note taker may notice that as one participant speaks, the others nod in agreement. This should be noted. They should also note when people disagree, feel uncomfortable with a topic or get excited.

Note Taking Strategies
Be sure that each note contains a brief summary of the topic being discussed, a note about who is speaking (in order), and an assessment of main themes and non-verbal communication. An example would look like

this: #4, if it lasts just 3 days, I'm alright but if it goes longer I feel sick, some nod in agreement. You can also note the general feeling of the group. For example, when asked about a program to deliver messages by mobile phone, group became excited and very interested. You can also note observations that you might have: participants seem to follow the lead of the oldest member when discussing mobile phone messaging.

Don't Note Everything
Only make a note when there is some reaction from the group, the "feeling" in the room changes, or you have an observation to make.

Type the Notes
Notes should be typed and attached to the transcript of the interview. Please keep in mind that notes are part of the data that will be analyzed. Be sure to make sure the notes are understandable and complete. Notes should be typed up as soon as possible after the FGD so that all the details will be remembered. Plan time (at least several hours) for doing this.

USAID/HEMAYAT PROJECT
Communication Assessment FGD Demographic Screener

#	Topic	Answer Key (tick or write in unless otherwise indicated)	Answer Code	Skip
001	Date	|___|___|___|___|___|___|___|___| (DD/MM/YYYY)		
002	Start time of FGD interview (hours written in 24 hour clock, for example 8 pm = 20:00 hours)	Hours written in 24 hour clock, for example 8 pm = 20:00 hours	_____ hrs: _____ min	
003	End time of FGD interview (hours written in 24 hour clock, for example 8 pm = 20:00 hours)	Hours written in 24 hour clock, for example 8 pm = 20:00 hours	_____ hrs: _____ min	
004	Moderator	Insert staff member number	|___|___|	
005	Session Recorder	Insert staff member number	|___|___|	
003	Age	(In years, best estimate)	|___|___|	
004	Country of birth	☐ 01 = Afghanistan ☐ 02 = Iran ☐ 03 = Pakistan ☐ 04 = Uzbekistan ☐ 05 = Tajikistan ☐ 88 = Other (specify):_____	|___|___|	If not born in Afghanistan, go to 006.
005	Province of birth	☐ 01 = Badghis ☐ 02 = Baghlan ☐ 03 = Badakhshan ☐ 04 = Balkh ☐ 05 = Bamiyan ☐ 06 = Daikundi ☐ 07 = Farah ☐ 08 = Faryab ☐ 09 = Ghazni ☐ 10 = Ghor ☐ 11 = Helmand ☐ 12 = Herat ☐ 13 = Jawzjan ☐ 14 = Kabul ☐ 15 = Kandahar ☐ 16 = Kapisa ☐ 17 = Khost ☐ 18 = Kunar ☐ 19 = Kunduz ☐ 20 = Laghman ☐ 21 = Logar ☐ 22 = Nangahar ☐ 23 = Nimroz ☐ 24 = Nuristan ☐ 25 = Paktia ☐ 26 = Paktika ☐ 27 = Panjshir ☐ 28 = Parwan ☐ 29 = Samangan ☐ 30 = Saripul ☐ 31 = Takhar ☐ 32 = Uruzgan ☐ 33 = Wardak ☐ 34 = Zabul	|___|___|	

#	Topic	Answer Key (tick or write in unless otherwise indicated)	Answer Code	Skip
006	Education	☐ 0…no formal education ☐ 1…1–2 years formal education ☐ 2…finished primary school (4th Grade) ☐ 3…some secondary school ☐ 4…finished secondary school (12th grade) ☐ 5……some university ☐ 6……finished university or higher)	|___|	If no formal education, go to 008. If 1–6, go to 007.
007	Education (specific)	|___|___| (years formal education)	|___|___|	
008	Civil Status	☐ 1 = Not married ☐ 2 = Currently engaged ☐ 3 = Currently married ☐ 4 = Widowed ☐ 4 = Separated ☐ 5 = Divorced	|___|	FINISH and Thank the participant.
009	Occupation	☐ 0 = Not currently working ☐ 1 = Student ☐ 2 = Farmer ☐ 3 = Military ☐ 4 = Police ☐ 4 = Religious leader/mullah ☐ 5 = Shop keeper ☐ 6 = Teacher ☐ 7 = Other (specify): _____	|___|	