FRAMEWORK CONTRACT COM 2011 – LOT 1 “STUDIES AND TECHNICAL ASSISTANCE IN SECTORS”

ASSESSMENT OF NUTRITION INTERVENTIONS IN BPHS AND EPHS

Letter of Contract N°2014/340066

FINAL REPORT

Public Nutrition Department (PND)

Ministry of Public Health (MoPH)

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ABBREVIATIONS AND ACRONYMS

ACF	Action Contre la Faim
AHO	Alliance of Health Organizations
AMI	Aid Medical International
ARTF	Afghanistan Reconstruction Trust Fund
BF	Breastfeeding
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
CGHN	Consultative Group of Health and Nutrition
CHC	Comprehensive Health Centre
CMAM	Community Management of Acute Malnutrition
CSO	Central Statistics Office
DFATD	Department of Foreign Affairs, Trade and Development
ECF	Exclusive Breastfeeding
EPHS	Essential Package of Hospital Services
FGD	Focus Group Discussion
GAIN	Global Alliance of Improved Nutrition
GCMU	Grant & Contract Management Unit
GDI	Gender Development Index
IDI	In-depth Interview
IRB	Institutional Review Board
IYCF	Infant Young Child Feeding
MCH	Mother and Child Health
MDG	Millennium Development Goal
MICS	Multi Indicator Cluster Survey
MOHE	Ministry of Higher Education
MoPH	Ministry of Public Health
NAF	Nutrition Action Framework
NEI	Nutrition & Education International
PND	Public Nutrition Department
PPA	Performance-based Partnership Agreement
PPHO	Provincial Public Health Office
QA	Quality Assurance
SC	Sub Centre
SEHAT	System Enhancement Health Action in Transition
SOP	Standard Operating Procedures
TAG	Technical Advisory Group
TCA	Thematic Content Analysis
WHO	World Health Organization

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EXECUTIVE SUMMARY

1. Introduction

Nutrition component is an important element in the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). Despite some progress toward improving nutrition status, there is still long way ahead. To explore ways how nutrition services could be improved, this study was conducted. It was done through assessing the current level of implementation, identifying related barriers/gaps, opportunities and elaborating recommendations for operationalizing nutrition activities.

A qualitative methodology was adopted through conducting 49 interviews (24 of them based on in-depth interviews and 25 others based on structured questionnaires) and the participants were recruited as part of purposive sampling in six provinces. The collected data underwent thematic content analysis (TCA).

2. Results

A total of five themes emerged through TCA. They included the following:

1. Staffing, Training and capacity development,
2. Management and support services;
3. Service delivery;
4. Exposure to additional support/interventions;
5. Policy, planning, monitoring and evaluation mechanisms.

2.1 Staffing, training and capacity building

The study found that, in response to the insufficient human resources for nutrition, additional staffing is required at national, provincial and health facility levels. Meanwhile, it was widely expected that Public Nutrition Department (PND) play a prominent role in the capacity building of staff in nutrition service delivery. Therefore, the need for adding more experts to the PND, adding nutrition officers at district level (District Nutrition Officers) or adding provincial nutrition supervisors under PNO and adding at least one nurse in each health facility are major findings of the study in this regard.

Majority of the visited provinces and health facilities did not have trained staff. Only the health facilities of few provinces (Herat and Saripul) comparably had more trained staff. In at least two of the provinces, representatives of the BPHS NGOs expected Provincial Public Health Office (PPHO) and Provincial Nutrition Officer (PNO) to provide support which PNO could not do. While the overall perception at central level is that BPHS NGO should be actively involved in the capacity building of Provincial departments of MoPH, the perception in the field, it is opposite.

2.2 Management and support services

The management and support services for nutrition service delivery were found inadequate both from Provincial Public Health Office and NGOs point of view in terms of insufficiency of supervisory support, poor technical and managerial quality, and low frequency of monitoring and supervision. The allocation of Provincial Nutrition Officers (PNOs) at the country level is unfair as they have been posted irrespective of the number of health facilities in each province. The same was the case with BPHS NGOs who had assigned a person as focal point for nutrition component who were having the nutrition responsibility as an ancillary task which was not found adequate.

In the meantime, the study found that Provincial Public Health Directors (PPHD) do not offer adequate oversight for strengthening nutrition component and his coordination with PNO is severely inadequate.

The study found that the current coordination mechanism for nutrition component is neither adequate nor effective and most of the discussions in these meetings are usually not related to strengthening the nutrition component of BPHS/EPHS. In addition, all provinces have a PNO and each BPHS

implementing NGO has a focal point for nutrition component. Yet the study found that with the current staffing arrangement, the nutrition service delivery and management at clinic, provincial and national levels is sub-optimal and insufficient. Therefore the current arrangements at national, provincial and clinic level need reinforcement in terms of staffing, resources, technical and managerial elements.

2.3 Service delivery

The following nutrition services are expected to be offered according to the revised BPHS and EPHS guidelines:

A. Assessment of malnutrition (population level)
B. Prevention of Malnutrition
B1. Vitamin A supplementation to all children 6 months to 59 months
B2. Promotion of Iodized Salt
B3. Promotion of Balanced Micronutrients rich food
B4. Support and promote Exclusive Breastfeeding
B6. Promotion of complementary feeding
B7. Community food demonstration
B8. Iron Folic Acid supplementation
B9. Promotion of maternal nutrition
B10. Underlying causes of malnutrition
C. Treatment of malnutrition
C1.Micronutrient deficiency disorders
C2. Outpatient treatment of SAM
C3. In-patient treatment of SAM
D. Surveillance and Referral
D1. Clinical-based surveillance
D2. Screening and referral
D3. Reporting

However, the study found that majority of the health facilities especially CHCs and BHC do not offer a complete package of nutrition services. Some sub-components i.e. food demonstration, community assessment, and surveillance system were not offered by majority of the visited health facilities (Please see table 8 for details). Screening dubbed as growth monitoring was performed in all visited health facilities, however, in one of the health facilities it was performed by guard of the health facility

The study found that the Health Management Information System (HMIS) cannot capture data about the provision of all sub components of nutrition. Currently, the it captures information only on screening, and treatment of malnutrition.

The study found serious problems with regards to supply of nutrition commodities in some health facilities. Although during the visit there was no stock out of nutrition commodities but in few health facilities stock out of nutrition commodities were seen at least once over the last six months.

The participants of the study acknowledged that EPI and TB are more successful than nutrition. Majority of them stated the reason behind this fact is because there is more publicity and overall commitment for EPI while for nutrition, limited attention is offered.

According to the group discussions with clients conducted as part of this study it was revealed that a significant number of the clients participating in the discussion (around 70%) had some knowledge about the key messages (i.e. exclusive breastfeeding, complementary feeding) however, they fell short of defining/identifying some key issues related to malnutrition i.e. stunting, malnutrition.

2.4 Exposure to additional interventions aimed at filling gaps

While the interventions by other organizations such as UNICEF, Canada-DFATD and other implementing partners, such as, Supplementary Feeding Programme (SFP), and Integrated Management of Acute Malnutrition (IMAM) were welcomed by most of the participants, there were few participants who did not share the same opinion stated that such vertical services under the current arrangement are counter-productive. It was recommended by few PNOs that the implementation of

additional projects related to strengthening nutrition service delivery should be managed by MoPH in which PPHOs should play active role.

It was also revealed that only in facilities where, with the help of other organizations, IMAM support is implemented they have all the necessary equipment and supplies for providing a comprehensive package of nutrition services. Other health facilities where nutrition component is not supported by other organizations merely provide screening and referral to other facilities.

The study also found that MoPH does not have adequate control in the oversight and supervision of pilot projects related to nutrition services as a result it is not known if these pilot projects are useful in strengthening the nutrition component.

2.5 Planning, monitoring & supervision from nutrition service delivery

According to the study although current BPHS/EPHS SEHAT proposals have been reviewed by the Provincial Public Health Director but almost all of them are not responsive technically and financially toward effective nutrition service delivery as highlighted in BPHS and EPHS.

It was revealed that MoPH does not maintain a proper mechanism at central and provincial level so that regular supervisory support could be offered to provinces and health facilities respectively. In addition, there is no specific checklist available for the monitoring and supervision purpose of nutrition activities. Further a need was perceived for conducting further studies aimed at identifying challenges and problems about specific sub-components of nutrition.

3. Conclusions

3.1 Current level of the implementation of nutrition component

The study reveals that presently the nutrition component has been under-staffed and under resourced at service delivery, provincial and national levels. As a result optimal nutrition service delivery could not be offered through BPHS and EPHS. The situation is further worsened by absence of a consistent programme of training for health workers in nutrition. Not all components of nutrition could be delivered appropriately because there are either no standard operating procedures or most of the staff intended to follow them are not aware of these guidelines.

3.2 Barriers for strengthening nutrition service delivery

The study found that some of the notable barriers to offering nutrition service delivery are as follow:

- The current management arrangements at national, provincial and service delivery level are less sufficient and thus need to be reinforced. Health facilities receive limited supervision from provincial supervisors.
- Funding under BPHS and EPHS is not being effectively utilised for strengthening the nutrition element
- There has been no desirable investment on the Public Nutrition Department (PND) despite having great potentials for making substantial contribution.
- There is no financial mechanism for nutrition component partly because there is no data available about the costing of nutrition activities for the equitable implementation through BPHS implementers i.e. cost per capita for nutrition service delivery
- Lack of staff particularly female staff, lack of space for nutrition service delivery, lack of standard operating procedures (SOPs), limited outreach activities for nutrition service delivery, poor quality of the nutrition services delivered and poor behaviour of staff at health facilities.
- Bad behaviour of some HF staff, long waiting hours, lack of privacy inside health facilities, stock out of nutrition commodities and receiving limited attention from staff by clients. It was observed in at least one of the health facilities, a male health worker was even physically harassing some female clients who were in the waiting hall.
- Nutrition component not being well-mainstreamed into the quality assurance toolkits

3.3 Opportunities for strengthening nutrition service delivery

The study surfaced the following are the opportunities with regards to strengthening nutrition service delivery:

- Emergence of Public Nutrition Department as a dynamic and capable department of MoPH staffed with qualified experts having great potentials for offering good leadership toward overseeing nutrition service delivery through BPHS and EPHS across the country. Most of the members of the PND have good understanding of BPHS and EPHS and have practical experience of their implementation
- There is sufficient funding secured for the provision of BPHS and EPHS (SEHAT) and nutrition component is an integral part of it. The only issue is how the funding could be re-directed toward strengthening the nutrition component
- There are a number of stakeholders and development partners who are willing to provide support to strengthening nutrition component which have piloted several interventions providing useful insight for providing improved nutrition service delivery
- NGOs implementing BPHS and EPHS which have got sufficient experience over a period of the last decade. They were found willing to provide optimized nutrition services and have great potentials for making significant contribution to improving the nutrition status of the Afghan population by strengthening nutrition component

4. Recommendations

To strengthen nutrition component of the BPHS and EPHS, overall commitment is needed at all levels. This commitment should be translated to providing financial and technical assistance for upgrading the current arrangements for nutrition service delivery across the country. Replicating the approach of Canada-DFATD interventions in Saripul and Herat where nutrition service delivery is managed as part of a coordinated mechanism could be very helpful. In addition, a decent investment needs to be made toward strengthening the existing systems for service delivery at national, provincial and local levels. These measures are necessary to bolster the stewardship role of the Ministry of Public Health and ensure the sustainability of all programme interventions made in relation to strengthening the nutrition component of BPHS and EPHS. To materialise a positive change in this regard, the policies should be translated to user-friendly strategies and guidelines that could be effectively used at service delivery levels.

The following is a list of recommendations made based on the findings of the study:

4.1 Recommendations for PND

1. There should be a consistent and continued programme for trainings and other capacity building activities at provincial level and national level capacity building. PND should be empowered to train the trainers stationed at provincial level and then provincial level Master trainers from PPHO and BPHS NGO should be enabled to cascade trainings to health facility staff.
2. Until an additional nutrition nurse is approved, PND needs to work with the Human Resources Department of MoPH as well as NGOs to ensure the job description of all health facility staff should be extensively revised and specific bullets should be added so that the staff is committed to strengthening the nutrition component. GCMU could be very helpful in facilitating this process.
3. MoPH-PND should develop a TOR for the BPHS/EPHS implementing NGO Nutrition Focal Points. In addition, the TOR of the Provincial Nutrition Officers should be revised in a manner that the position holder give sufficient time to supporting nutrition component of BPHS and EPHS. The most important gap in the current TOR of PNO is that contains no responsibilities specifically related to strengthening the nutrition component of BPHS. Meanwhile, the TOR does not specifically mandate and guide PNO to be involved in monitoring BPHS NGOs to monitor their performance in nutrition service delivery.

4. To enhance the efficiency of PNOs, they should be assisted to have proper monthly action plans and have effective monitoring and supervision tools. PNOs should also be assisted to maintain a functioning system of follow-up and reporting to PND.
5. To fix the unfair posting of PNOs, provinces should be categorised based on the number of health facilities. Considering the budgetary restriction, there should be an assigned nutrition officer to take of the health facilities in a district. There could be up to 2-3 provincial nutrition supervisors in each province working under the oversight of PNO having a clear scope of work for supervising the nutrition component in BPHS/EPHS health facilities.
6. The issue of gender sensitivity should be adequately considered in the planning, provision of services and capacity building related to nutrition service delivery.
7. The current guidelines are very lengthy (100-200 pages) and as a result staff do not have time to read all them. To ensure the guidelines are implemented properly, SOPs need to be translated so that health facility staff can offer all required nutrition services step-by-step.

4.2 Recommendations to GCMU and other stakeholders

8. Poor infrastructure and limited space was cited a significant hindrance to nutrition service delivery. PND should check with the Engineering department to ensure that the need for nutrition service delivery is adequately considered in the standard design for constructing buildings of the health facilities. For short term impact, a rapid assessment of infrastructure gap should be to allocate enough budget for renovation and reconstruction.
9. To expand the provision of nutrition service delivery to communities, the nutrition service delivery should be properly integrated into the current mobile health team activities so that the services are provided both at health facility-based and community based. In addition, other outreach setups should be explored for the provision of outreach service delivery.
10. There should be national and provincial level steering mechanisms for coordination. The mechanism should be led by PND in order to facilitate close coordination and cooperation between the various partners i.e. BPHS/SEHAT NGOs, donors, UN agencies that are involved in implementing nutrition programmes. The terms of reference of this coordination committee should be developed in a consultative manner.
11. Quality Assurance standards and existing Standard Operating Procedures (SOPs) should be developed and/or revised in a manner that they should adequately address the nutrition component.
12. At health facility level especially BHCs and Sub centres, a nurse should be added so that he or she is a focal person for delivering nutrition services in health facilities.
13. Regarding monitoring, donors should support MoPH in monitoring the implementation of BPHS interventions through quality and quantity evaluation grids that encompass budget component spent on nutrition at each budget reimbursement; development of an external complaint mechanism and external monitoring system.

4.3 Recommendations to other stakeholders

14. The interventions by WFP, UNICEF, etc. should be done in complete coordination with PPHO and BPHS staff as is done in the case of Canada DFATD.
15. Prior to designing interventions for strengthening nutrition component, the issue of continuity of them should be strictly taken into consideration.

4.4 Recommendations to MoPH leadership

16. As per the structure of MoPH, the Public Nutrition Department comes under the General Director of Preventive Medicine. The fact that improving nutrition of the population need corporate efforts which are not limited to MoPH, the department in long term should be upgraded and placed in the organogram in a manner that it could easily establish coordination with other sectors i.e. Rural Rehabilitation, Urban Development, Industries, etc. under the oversight of the Leadership of the Ministry of Public Health.
17. MoPH needs to conduct further researches and studies to explore how each sub-component could be improved. One of the areas is to determine the current cost per capita for nutrition

service delivery and have it compared with the desired cost per capita and then make investment accordingly.

Keywords:

BPHS, EPHS, Nutrition, Assessment.

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Finally, I would like to extend my sincere thanks to European Union (EU), Ministry of Public Health (MoPH) and other stakeholders i.e. USAID, WHO, Canada-DFATD, ACF, etc. for providing their inputs and finalization of the study report.

2. FOREWORD

This document is the final report of the project “Assessment of nutrition interventions in BPHS and EPHS. This project was proposed by the Public Nutrition Department and launched by the EU Delegation in Afghanistan and its beneficiary is the Ministry of Public Health in Afghanistan.

Nutrition component is an important element of the Basic package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). Ministry of Public Health (MoPH) with the support of national and international organizations has been offering health services to Afghan population according to BPHS and EPHS. Despite a significant progress toward the expansion of BPHS and the EPHS in the country together with the additional support by other organization in this regard, the nutrition service delivery is not at an optimal level as it has received less attention so far.

In response to this situation, there was a perceived need to have data by looking into the current level of nutrition service delivery and identifying the barriers and opportunities for the improvement of nutrition service delivery. The data in this regard will provide significant insight what interventions are working and what are needed. Therefore, it was agreed by MoPH and development partners that an operational research be conducted under the oversight of the Public Nutrition Department (PND). Dr. Qudratullah Nasrat was assigned as Study Expert to conduct this evaluation. The European Union (EU) generously provided financial and technical assistance for this endeavour.

This assessment provides insights to the Ministry of Public Health (MoPH) donors, NGOs implementing BPHS/EPHS and other stakeholders in delivering nutrition service delivery in Afghanistan how nutrition service delivery could be improved. The assessment draws specific recommendations for improving nutrition component through BPHS/EPHS.

It is therefore our pleasure to present *Assessment of Nutrition Interventions in BPHS and EPHS* which will guide the user through the entire process of designing, planning, implementing, and reporting reliable nutritional assessment.

3. BACKGROUND AND CURRENT SITUATION

Given the poor nutrition related indices pointed out by the Afghanistan National Nutrition Survey (2013), tackling chronic malnutrition and micronutrient deficiencies having a very high prevalence in Afghanistan require redesign of interventions. This needed to be done by identifying new approaches and adopting lessons learned.

Food insecurity, poor education and overall status of women (gender dynamics), traditional practices, poor hygiene and sanitation, overall poverty, uneasy access to health services etc. altogether lead to malnutrition in Afghanistan. As pointed out by the Afghanistan National Nutrition Survey (2013), the result is that about 40.9% of children under 5 years old are stunted. In addition, 9.5% others suffer from Acute Malnutrition (wasting). Ironically, only 58.4% of infants below 6 months in Afghanistan are

exclusively breastfed by their mothers. Further, women and children suffer from Iron deficiency (more than 29% for children, and 40.7% for women have iodine deficiency also 26% children and 24% of women suffer from iron deficiency, 50% of children have vitamin A deficiency, 81% of children and 95% of women suffer from vitamin D deficiency which are other key features of malnutrition in this country. Insecurity has added further challenges in this regard.

Although the recent emergency driven approach executed by the government in coordination with NGOs has been effective, they have yet to offer desired results. One of the issues pertinent to this is that the health care system of Afghanistan is clearly under-funded (WHO, 2006). On the other hand, although nutrition is an integral component of BPHS and EPHS policies, yet there are numerous bottlenecks with regards to its optimized implementation. This is while, as per the policy of the Ministry of Public Health (MoPH), primary and hospital services have been framed into BPHS and EPHS offering a framework for offering health services across the country. Yet stumbling in provision of nutrition service delivery, this has been potentially effective in offering basic health services to the needy population as part of a decentralized service delivery approach meeting their immediate and basic health needs to some extent.

TABLE 1: THE SEVEN ELEMENTS OF THE BPHS AND THEIR COMPONENTS

1. Maternal and New-born Care	1. Antenatal care 2. Delivery care 3. Postpartum care 4. Family planning 5. Care of the new-born
2. Child health and Immunization	1. Expanded Programme on Immunization 2. Integrated Management of Childhood Illnesses (IMCI)
3. Public Nutrition	1. Prevention of malnutrition 2. Assessment of malnutrition
4. Communicable Disease Treatment and Control	1. Control of tuberculosis 2. Control of malaria 3. Prevention of HIV and AIDs
5. Mental Health	1. Mental Health education and awareness 2. Case identification and treatment
6. Disability and Physical Rehabilitation Services	1. Disability awareness, prevention, and education 2. Provision of physical rehabilitation services 3. Case identification, referral and follow-up
7. Regular Supply of Essential Drugs	1. Listing of all essential drugs needed

MoPH has recently restructured the delivery of BPHS through System Enhancement for Health Action in Transition (SEHAT) programme under the supervision of the World Bank administered by Afghanistan Reconstruction Trust Fund (ARTF) which adopts a sector-wide approach and aim to coordinate all types of funded interventions in a progressive manner.

Administered by WB, the implementation of the following 3critical components have been ensured since 2013:

- BPHS and EPHS
- MoPH management capacity and system development
- Management

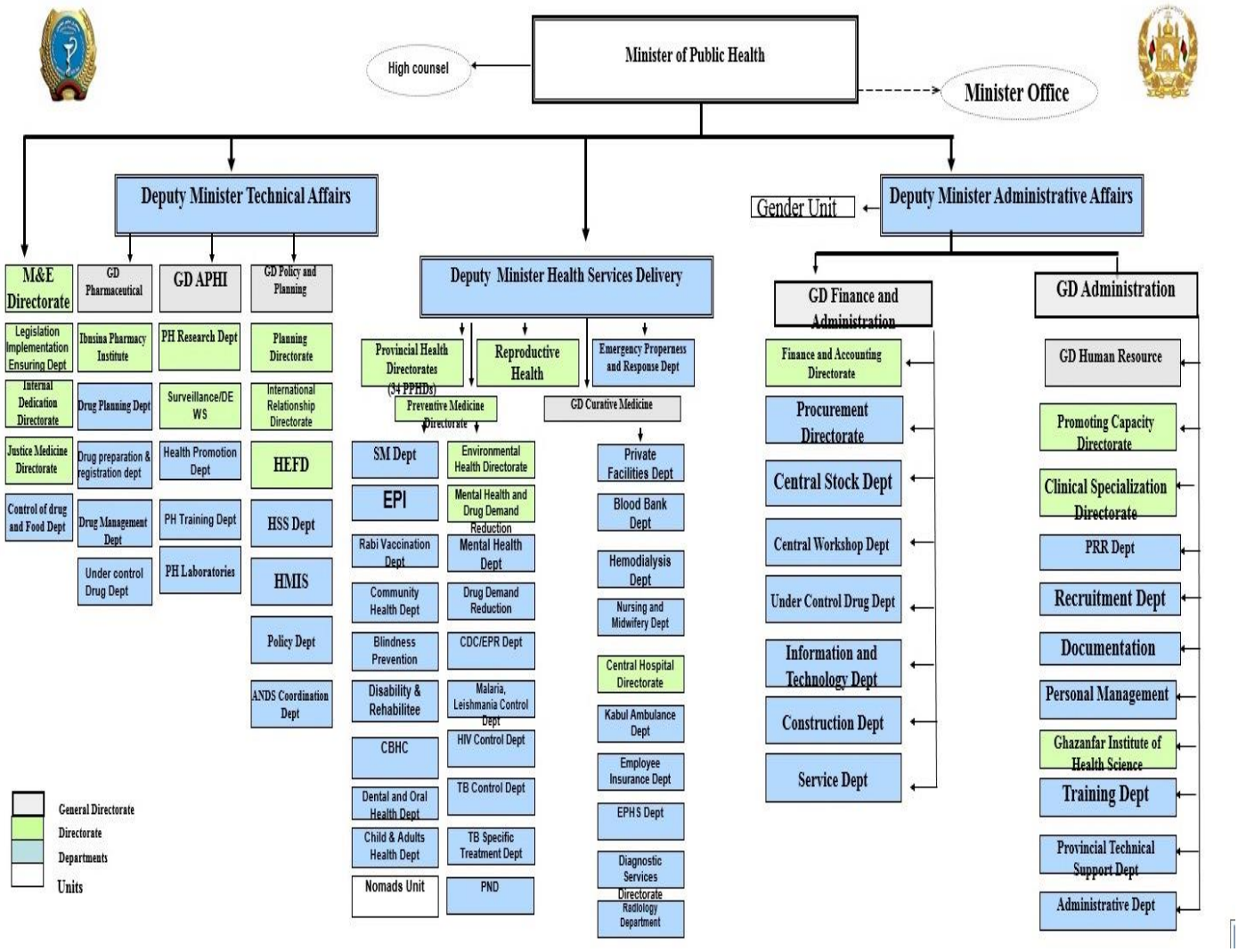
MoPH sets precedence by executing a very high number of contracts (27 contracts) aimed at BPHS and EPHS with qualified NGOs in 18 provinces of the country. These contracts have been Performance-based Partnership Agreements (PPA) and are valid with the relevant NGOs for a period of three years. Through this, it has been ensured that selective primary care and hospital services are offered in 18 provinces as part of a standardized package as recommended by the MoPH.

As highlighted by the Terms of Reference for this study, despite all these developments, overall NGOs have been unable to effectively deliver the nutrition component for several reasons. While lack of technical capacity, lack of health professionals and high workload of health staff in health facilities

were perceived some of the reasons, a study was needed to identify and document bottlenecks and genuine shortcomings in this regard.

The recent efforts of the Public Nutrition Department (PND) of MoPH toward functionalizing the nutrition component of BPHS have been a notable endeavour. According to PND, it mobilized two trainers in 2011 in each province by conducting a Training of Trainers (ToT) workshop for them. They were expected to cascade the imparted trainings further at health facility and community level. However, this initiative could not give pay off as expected for reasons that are explored via this study.

FIGURE 1: ORGANOGRAM OF THE MINISTRY OF PUBLIC HEALTH



MoPH still has long way toward having a comprehensive and coordinated intervention with regards to improving nutrition staff of Afghan population. What desired is that NGOs, UNICEF, WFP, WHO, Canada-DFATD, WB, USAID and EU which are the main stakeholders in the country come together and adhere into a coordinated and comprehensive approach toward improving the nutrition status.

The current interventions are only in small scale and confined to only few organizations. For example, Save the Children, World Vision and Action Contre la Faim (ACF) are so far the only NGOs that offer on the job training programmes in ten provinces of Afghanistan. These capacity building programmes are aimed at strengthening the nutrition component of BPHS. Apart from that, the interventions of Global Alliance for Improved Nutrition (GAIN) have been aimed at only tackling micronutrient deficiencies and stunting by working with private sector and UN. Likewise, Nutrition & Education International (NEI) has been addressing chronic malnutrition (stunting) by promoting value chain soy industry development in Afghanistan since 2003. Meanwhile, with the support of Canada - DFATD,

and technical support of WHO and UNICEF, efforts are underway toward developing a comprehensive Nutrition Surveillance and Monitoring System.

In a nutshell, the nutrition component implementation has seen no significant improvement in spite of all the measures already taken which has led to some progress in this regard as reflected in the recent national nutrition related surveys. The status quo genuinely warrants assessment of the situation in-depth at various levels (health facility, provincial and national level). The in-depth assessment needs to find out the crucial gaps and impeding factors based on which necessary recommendations could be drawn which could lead to having fully functional and integrated nutrition service delivery in hospitals and all tiers of BPHS.

For this purpose the consultancy services have been sought in order to conduct a comprehensive evaluation of the nutrition services and identify gaps in quality and barriers in access of women as well as to provide evidence based recommendations for improving the operationalization of the nutrition activities as part of the BPHS and EPHS.

4. STUDY PURPOSE

The study aimed at identifying current situation, gaps, and draw recommendation around the following domains as part of an extensive analytical approach:

1. Training and capacity development
2. Management and support services
3. Service delivery
4. Exposure to additional support/interventions for filling gaps
5. Monitoring and evaluation mechanisms

4.1 Global objective

To improve the operationalization of the nutrition activities as part of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS)

4.2 Specific objective(s)

- To assess the level of implementation of nutrition components in the BPHS and EPHS
- Identify related barriers and opportunities for strengthening nutrition service delivery and to identify factors that lead to both low and high performance.
- Elaborate recommendations for each level to operationalize nutrition activities in the BPHS and EPHS with focus on gender sensitivity of the interventions.

5. STUDY QUESTION

The study question was: How the implementation of the nutrition component of BPHS and EPHS could be improved in Afghanistan?

6. STUDY METHODOLOGY

6.1 Study setting

The study was conducted in six provinces which were selected to represent a wide representation of the donor-funded provinces. They included the following:

TABLE 2: DESCRIPTION OF PROVINCES WHERE THE STUDY TOOK PLACE		
SN	Province	Donor
1	Herat	PCH+ DFATD (World Vision
2	Kabul city	Ministry of Public Health
3	Parwan	MOPH (Strengthening Mechanism)
4	Baghlan	USAID's Partnerships Contracts for Health (PCH)
5	Sare –e Pul	System Enhancement Health in Action Transition + Save the children
6	Ningarhar	SEHAT

Herat Province is located in the western part of the country having a total population of 1,780,000 (Central Statistics Office-CSO, 2013). The province has a total 100 health facilities including one regional hospital and 69% of these health facilities are staffed with at least one female health worker. The overall literacy rate is 26.5 in the province (MoPH-HMIS, 2012). Immediate basic health services (availability of a health facility in less than one hour) could be accessed by only 96%. Only 28% of population have access to safe drinking water (MoPH-HMIS, 2012). Canada DFATD has a programme of additional interventions aimed at filling gap in health service delivery.

Kabul Province is the capital of Afghanistan which is located in a valley having a population of 3,950,300 (Central Statistics Office –CSO, 2013). A total 157 health facilities (HFs) including 22 speciality hospitals are located in this province. A total 88% of all HFs are staffed with at least one female health worker. According to MoPH-HMIS (2012), the overall literacy rate is 47.5% in the province and the immediate basic health services (availability of a health facility in less than one hour) could be accessed by only 85%. Only 56% of population have access to safe drinking water (MoPH-HMIS, 2012). WFP, and UNICEF have had additional interventions in nutrition on an interval basis in this province.

Parwan province is located north of Kabul and surrounded by Bamian, Baghlan, Kapisa, Kabul and provinces. The population has been estimated as 631,600 (CSO, 2013). It has a total 68 health facilities and 62% of them are staffed with at least one female health worker. According to MoPH-HMIS (2012), the overall literacy rate is 28.5% in the province and the immediate basic health services (availability of a health facility in less than one hour distance) could be accessed by only 76% population. Only 19% of population have access to safe drinking water (MoPH-HMIS, 2012). The province has had very limited exposure to additional interventions by other organizations i.e. WFP, UNICEF, etc..

Baghlan Province is located in the north-east of the country on the main route connecting the capital with north and north east. The population of this province has been estimated as 741,690. It has a total 68 health facilities which 77% of them are staffed with at least one female health worker. According to MoPH-HMIS (2012), the overall literacy rate is 25.5% and immediate basic health services (availability of a health facility in less than one hour distance) could be accessed by only 53% population. Only 24% of population have access to safe drinking water (MoPH-HMIS, 2012). UNICEF had a vertical programme of additional nutrition interventions in 2012 which was implemented through ACF.

Sar-e-Pul province is situated in northern of the Afghanistan and bordering Jawzjan province in the North, Balkh province in the North-East, Samangan province in the South-East, Bamyan and Ghor provinces in the South and Faryab province in the West. According to Central Statistics Office (CSO, 2013), its total population is estimated as 532,000. The province has a total 50 health facilities and 79% of them are staffed with at least one female health worker. According to MoPH-HMIS (2012), the overall literacy rate is 10.5% and immediate basic health services (availability of a health facility in less than one hour distance) could be accessed by only 54% population. Only 12% of population have access to safe drinking water (MoPH-HMIS, 2012). Canada DFATD has an extensive programme of additional nutrition interventions in this province.

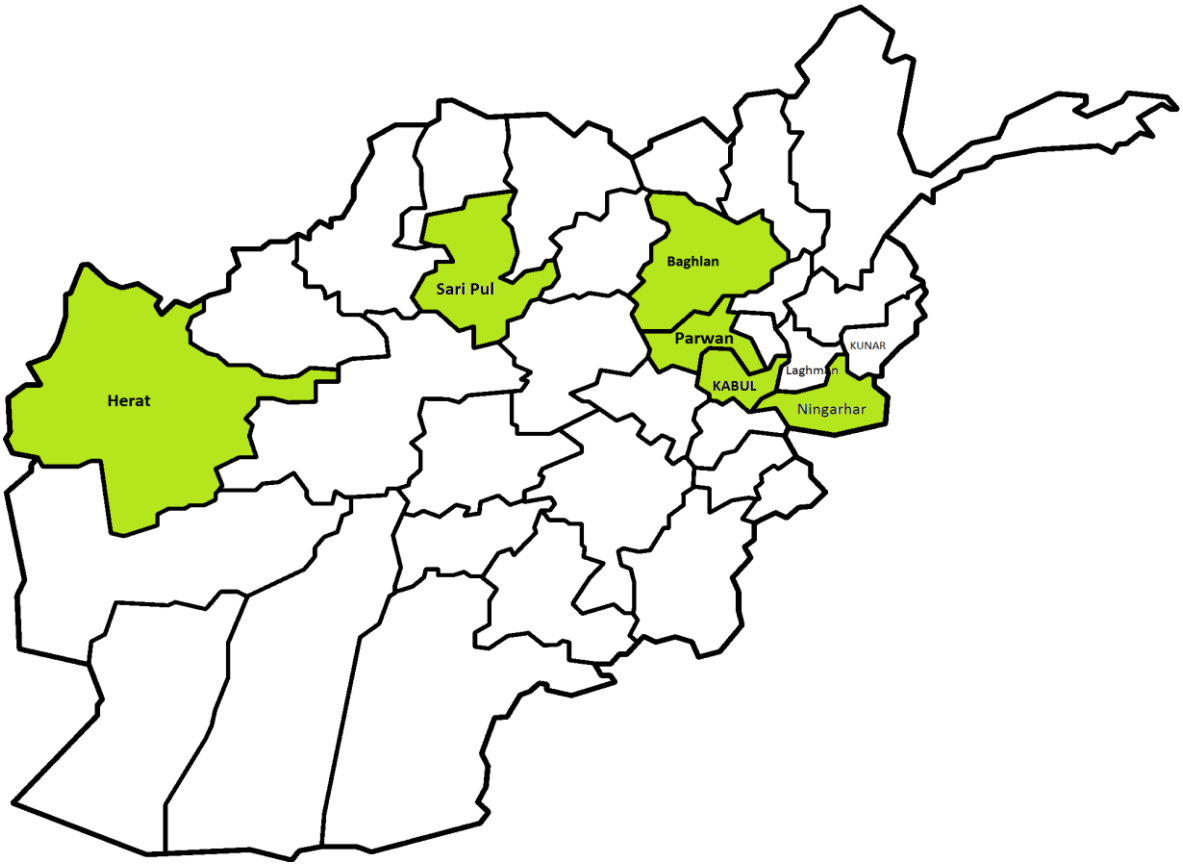
Ningarhar province is one of the eastern provinces of Afghanistan and its population has been estimated as 1,436,000 according to Afghanistan CSO (2013). It has a total 119 health facilities and

71% of them are staffed with at least one female health worker. According to MoPH-HMIS (2012), the overall literacy rate is 24% and the immediate basic health services (availability of a health facility in less than one hour distance) could be accessed by only 65% population. Only 24% of population have access to safe drinking water (MoPH-HMIS, 2012). Additional nutrition interventions have been on limited interval basis and the province has very limited exposure to additional interventions in nutrition.

TABLE 3: SITUATION OF THE PROVINCES WHERE THE STUDY WAS CONDUCTED

Parameters	Kabul	Ningarhar	Parwan	Baghlan	Herat	Saripul
Population	3,950,000	1,436,000	631,600	741,690	1,780,000	532,000
No of health facilities	157	119	68	68	100	50
No of HFs staffed with at least one female health worker	88%	71%	62%	77%	69%	79%
Overall literacy rate	47.5%	24%	28.5%	25.5%	26.5%	10.5%
Immediate access to basic health services	85%	65%	76%	53%	96%	54%
Access to safe drinking water	56%	24%	19%	24%	28%	12%

FIGURE 2: PROVINCES OF AFGHANISTAN WHERE THE STUDY WAS CONDUCTED



As agreed upon by the PND, EU and other stakeholders, the major criteria for the selection of provinces included the following:

- To represent a wide range donors as mentioned above
- Security
- Accessibility is not an issue and the provinces are not very remote

The assessment focused at three levels:

1. Service delivery at health facilities;
2. Provincial Stewardship in the Provincial Nutrition Officers;
3. MoPH Stewardship and role of the PND.

The fact that two provinces (Saripul and Herat) are selected from the provinces in which nutrition interventions are funded by Canada-DFATD under two different mechanisms, a comparison analysis is also part of this report (See Annex 4).

6.2 Literature search approach

The literature search was initiated by exploring the MoPH Resource Center which has readily available documents i.e. BPHS, EPHS, nutrition and other related policies and strategies. Additionally, there were around five references which were related to the world leading organizations such as Word Health Organization (WHO), and UNICEF. Additional reference documents such as Afghan policy documents and other publications that were locally available were received from the Resource Centre located in Afghan Ministry of Public Health (MoPH).

The Google Scholar search engine was also used to conduct more general searches. All searches were limited to research with nutrition and BPHS service delivery published in English, Pashto and Dari.

Aimed at finding relevant articles, key words were investigated that contained the words, “BPHS”, “EPHS”, “qualitative research in nutrition” and “Afghanistan”. It ensured that the search yield results on the literature were in English language. Articles in local languages were also considered.

There were more than 73 articles found, yet only 4 of them provided relevant information on nutrition service delivery in Afghanistan. They were found relevant and were of qualitative research nature which provided some inputs to explore how nutrition component could be operationalized in BPHS and EPHS. The rest of the documents which were not relevant to issues pertaining to access to nutrition services in Afghanistan were discarded.

TABLE 4: ARTICLES RETRIEVED

Database/Source	Search word	Total received	Used	Reasons for rejection
Google Scholar	Nutrition, Assessment, Qualitative, Afghanistan	63	2	Not relevant to context
MoPH Resource Center	Nutrition, BPHS, EPHS	8	3	Not relevant to context
Google Search	Nutrition Qualitative Afghanistan, BPHS	164	3	Not relevant to the context

6.3 Literature review

Although there are some studies related to nutrition services but none of them are similar to the study under discussion.

There has been a qualitative study conducted by Afghan Humanitarian Assistance Organization (AHAO) aimed at assessing if BPHS adequately address the programme design of public nutrition programme and actual implementation at various levels of health facilities in Afghanistan. Aimed at exploring the effectiveness of BPHS in improving nutrition status of Afghanistan population, a total 37 interviews with health facility staff and 20 interviews with key informants at the central as well as provincial level have been conducted. The study found that majority of the causes are out of the scope of health sector such as food insecurity, food hygiene and poverty.

Another assessment that is conducted in Afghanistan is called the national Risk and Vulnerability Assessment (NRVA) which is a mixed qualitative and quantitative national level survey which offers information that is required for the monitoring development progress. As a result, the government and

involved stakeholders would have the opportunity to formulate development policies and programmes accordingly.

Another survey of in similar context is Afghanistan National Nutrition Survey 2013. However, the nature of the study is different than the study under discussion as it has aimed to review the current nutritional situation establish the trends and look for associate factors influencing the nutritional status of population in Afghanistan. The survey is a cross sectional type of survey at household level as part of multi-stage (two-stage) cluster sampling technique was used.

6.4 Study design and rational for choice of methods

Elaborated in the subsequent sections, this study is qualitative in design employing an exploratory research design which is best suited to explore 'how' related topics (Green & Thorogood, 2009). This included in-depth interviews and focus group discussions (FGDs) in the target provinces. Aimed triangulating information, a specific set of questionnaire was used aimed at exploring the delivery of sub-components of nutrition components of BPHS and EPHS. Meanwhile, observation of nutrition service delivery in health facilities and review of the HMIS and other records also constituted integral part of the study methodology.

6.5 Settings

The data was collected from 24 workplaces including 12 HFs located in six provinces as earlier mentioned. The remaining 12 workplaces included offices of the PNOs and NGO Nutrition Supervisors. In each province, interviews were conducted with relevant people working in facilities from the following categories:

1. Basic Health Centre (BHC) or Comprehensive Health Centre (CHC)
2. District Hospital (DH) or Provincial Hospital (PH)
3. Public Nutrition Officer based in PPHD
4. BPHS NGO Nutrition Focal Point based in BPHS Provincial Office

In addition, involving community midwives, and community members (clients), a total six Focus Groups Discussions (FGDs) took place in all six provinces. The focus groups were selected according to study TOR, and representing a wide range of different group from the clients representing local communities. From gender perspective, the participants of all FGDs were female clients and community midwives. The fact that the combination of the participants were mixed (community midwives and clients), any potential bias was minimised by effective moderation. Qualitative research was necessary to explore views in depth. The research investigated a broad range of issues, starting with as much of a 'blank sheet' as possible to explore participants' own perspectives.

6.6 Sample definition

The study involved a total 49 interviews. Among them, a total 24 were in-depth interviews (IDIs) with the following purposively sampled respondents: 11 program staff (10 men, one women), 12 clinic staff (three men, nine women), and one policy level staff in MoPH Kabul. There was a deviation in the number of IDIs foreseen for female programme staff. Only one female programme staff could be interviewed because all nutrition programme supervisors were male and thus female programme staff could not be found. However, this was compensated in conducting IDs with clinical staff. Instead of the foreseen four female clinic staff, total seven clinic staffs were in-depth interviewed. Meanwhile, one of the foreseen interviews in Baghlan could not take place because there was no PNO in one of the provinces.

Among the 49 interviews, a total 25 interviews were conducted based on the structured questionnaires (See Annex 1 a, b, c, d) targeting PNO, Provincial Nutrition Supervisor of each NGO, and health facility staff in each province. The structured questionnaires were used to capture information from the target respondents about the sub-components of the nutrition component of BPHS. Capturing this

information about the status of the sub-components of nutrition service delivery was deemed not feasible using other methods.

In addition to six FGDs, another group discussion took place with representatives of donors, policy makers and NGOs implementing nutrition in Afghanistan. The findings of the discussion with donors and policy level actors i.e. WHO, UNICEF, WFP, MoPH, etc. also provided significant input to the findings of this study. The in-depth interviews and FGDs with female clients were facilitated by a female assistant from the relevant health facility.

The fact that saturation achieved in interviewing key informants in the target provinces, no need was perceived for conducting additional IDIs and FGDs in each province. Thus, the interviews were conducted in all six provinces as initially planned without considering the foreseen additional interviews.

TABLE 5: DESCRIPTION OF THE BREAKDOWN OF THE 49 INTERVIEWS CONDUCTED

Province	Institution	HF Type	Designation	Gender		Questionnaire	FGD	IDI
				Male	Female			
Kabul	MOPH	NA	Policy maker	1				1
	PPHO	NA	PNO	0		0		0
	BRAC	NA	Nut. Supervisor	1		1		1
	SM	DH	Hospital Director	1				1
		CHC	Midwife	1	1	1		1
		CHC	Clients+ midwives		6		1	
	Total			**4**	**7**	**2**	**1**	**4**
Baghlan	PPHO	Office	PNO	0		0		0
	BDN	Office	Supervisor	1		1		1
		DH	Hospital Director	1		1		1
			Midwife		1	1		
			Clients		1		1	
		CHC	MD+Head	1	0	1		
			Midwife		1	0		1
		BHC	MD	1		1		0
	Total			**4**	**3**	**5**	**1**	**3**
Saripul	PPHO	Office	PNO	1		1		1
	BDN	Office	Supervisor	1		1		1
		BHC	MD		1	1		1
		CHC	Midwife		1	1		
			MD		1	1		1
			Nurse		1	0		1
			Clients		1		1	
				2	**5**	**5**	**1**	**5**
Ningarhar	PPHO	Office	PNO	1		1		1
	AADA	Office	Supervisor	1		1		1
		DH	MD		1			1
			Nurse	1		1		
			Clients		1		1	
		BHC	MD	1		1		1
			Midwife		1	1		0
				4	**3**	**5**	**1**	**4**
Parwan	PPHO	Office	PNO	1		0		1
		CHC	MD		1			1
			Midwife	1		1		1
			Clients		1		1	
		BHC	MD+Head		1	1		
			Midwife		1	1		1
				2	**4**	**3**	**1**	**4**
Herat	PPHO	Office	PNO	1		1		1
	BDN	Office	Supervisor	1		1		1
		DH	MD		1			1
			Nurse	1		1		

Table 5: Description of the breakdown of the 49 interviews conducted								
Province	Institution	HF Type	Designation	Gender		Question naire	FGD	IDI
				Male	Female			
			Clients		1			
		BHC	MD	1		1		
			Midwife		1	1		
						4	**3**	**5**
Grand Total				25	6	24	**1**	**4**

Table 6: Description of the IDI respondents in the study								
Code	Sex	Age	Marital Status	Occupation	Employer	Year in Service	Position	Province
P 1	Male	48	Married	Doctor	MOPH	23	Hospital Director	Kabul
P 2	Male	40	Married	Doctor	MOPH	10	PNO	Kabul
P 3	Female	52	Married	Midwife	MOPH	25	Midwife	Kabul
P 4	Male	33	Married	Doctor	BRAC	7	Supervisor	Kabul
P 5	Female	50	Married	Doctor	MOPH	13	PNO	Sari Pul
P 6	Male	29	Married	Doctor	BDN	5	Supervisor	Sari Pul
P 7	Male	28	Single	Nurse	BDN	3	Nurse	Sari Pul
P 8	Female	25	Single	Nurse	BDN	1	Nurse	Sari Pul
P 9	Female	36	Married	Doctor	BDN	8	Physician	Sari Pul
P 10	Male	60	Married	Doctor	MOPH	27	PNO	Ningarhar
P 11	Male	38	Married	Doctor	AADA	8	Supervisor	Ningarhar
P 12	Male	40	Married	Doctor	AADA	11	Director	Ningarhar
P 13	Female	40	Married	Doctor	AADA	8	MD	Ningarhar
P 14	Male	45	Married	Doctor	MOPH	15	PNO	Parwan
P 15	Female	28	Married	Midwife	SM	3	Midwife	Parwan
P 16	Female	30	Married	Midwife	SM	5	Midwife	Parwan
P 17	Male	37	Single	Doctor	BDN	8	MD	Herat
P 18	Male	45	Single	Doctor	BDN	13	Head of DH	Herat
P 19	Male	35	Married	Doctor	BDN	8	MD	Herat
P 20	Male	36	Married	Doctor	BDN	5	Supervisor	Herat
P 21	Male	35	Single	Doctor	BDN	6	MD	Baghlan
P 22	Female	40	Single	Midwife	BDN	8	Midwife	Baghlan
P 23	Male	28	Married	Doctor	BDN	4	Supervisor	Baghlan
P 24	Male	36	Married	Doctor	MoPH	9	Consultant	Kabul

6.7 Inclusion/exclusion criteria

Inclusion criteria

Only Afghan national residents (male and female) in both rural and urban areas have been included in the study.

Exclusion criteria

Those below 18 years of age, migrants from other countries, foreign workers, and individuals who declined to participate in study were not included in the study. A total 2 midwives and five clients declined to participate in the in-depth interviews and focus group discussions because they stated they do not have time to participate in the study. The midwives who declined to participate were replaced by other midwives in the same health facility. Likewise, the clients who declined to participate in the study were replaced by other clients in the same health facility. Therefore, the refusal by participant did not represent any deviation from the intended list.

6.8 Recruitment

The researcher sought the assistance of Public Nutrition Department (PND), Grant and Contract Management Unit (GCMU) of MoPH, NGO Managers and officials of the Ministry of Public Health (MoPH) in the target provinces who provided a list of staff of health facilities (HF). At all levels, recruitment was done by actively searching for volunteers among a pool of participants through word-of-mouth, ensuring that potential participants understand that participation was voluntary. The reason why volunteers were searched was to make sure participation in the study was voluntary and no coercision was associated. As mentioned earlier, there were few intended participants who declined participating in the study which had no negative impact on the findings.

6.9 Data collection methods

Interview guide containing semi-structured questions were developed to guide the discussion (See Annex 1). All of the interviews were recorded and noted down intensively and were later transcribed for analysis purposes. Moreover, to support the interviews, the following other methodologies were adapted as part of triangulation process to capture what is actually being delivered now:

- Observation
- Interviews based on structured questionnaires
- Review of the clinic records
- Quantitative HMIS data (See the attached quantitative checklist)

Interview guides has been designed in consultation with relevant stakeholders and appropriately used while being sensitive to the socio-cultural contexts of the participants. The interview guide covered collecting information around the following main areas:

1. Current nutrition service delivery situation in Afghanistan
2. Gaps and barriers in nutrition service delivery
3. Recommendations for improvement

6.10 Field testing

The interview guide together with the questionnaires was pre-tested with two participants (one health professional and a female client) which were also included as participants. The consultant could not find any reason why different provinces had to be selected for field testing the interview guide/questionnaires. The reasons why they both were included in the study are as follow:

- They both met the inclusion criteria.
- The modification brought to the interview guide did not represent a significant change. Thus the pilot test did not render any impact on data collection. As a result it was completely acceptable to include the data through pilot testing and there was no reason to discard the data.
- The gaps/missing in in the interview guide/questionnaire highlighted below were corrected verbally during the pilot testing.

The following modifications were made to the interview questions based on the outcomes of the pilot:

1. Introduction was added to one question (Question 14)
2. Two questions were reworded and shortened (Question 4 and 10)
3. Two questions were merged and aimed at fixing redundancy (Question 17)
4. Probing questions were added to two questions (Question 9 and 12).

6.11 Ethical consideration

Although official ethical clearance was not received from the Afghanistan Institution Review Board (IRB) but all necessary precautions were in place aimed at ensuring there was no ethical violation throughout this study.

To ensure participation is voluntary and coercion is avoided, a written informed consent was received from every participant which is a pre-requisite for the participation of a person in a research activity (Shahnazarian, et al, 2013). In addition, the interviewees were assured of their anonymity in writing through informed consent. To abide by the Afghan cultural norms where male cannot talk to women who have no prior acquaintance (Bagboy, 2010), only female participants who felt comfortable to be interviewed by male were vetted.

6.12 Analytical approach

All IDIs were recorded with the help of a digital sound recorder and subsequently the recorded voices were converted to verbatim transcripts by the researcher. The conversations, in local language, were translated from original verbatim into English verbatim so that analyses could be done accordingly. The recording helped the researcher make comprehensive notes, and convey messages actively (Green and Thorogood, 2004) so that a good basis for analysis could be made.

The transcripts were coded to categorize the data systematically. The first step involved formatting the interview data into tables. Each interview was put in a separate table. Secondly, a theme codebook was developed that included the definitions of the main themes and the various categories under each theme (Table 7).

Aimed at guaranteeing the confidentiality and anonymity, the interview notes were coded and secured in a locked cabinet. The entered data was secured in a password-protected folder which was safe from unauthorized access. These will be stored for five years and then destroyed.

TABLE 7: THEME CODE BOOK ILLUSTRATING HOW THE ANALYSIS IS UNDERTAKEN

Codes	Themes
1.1. Staffing 1.2. Training and Capacity Development	1. Training and capacity Development
2.1. Role of PNO 2.2. Role of PPHO 2.3. Coordination mechanism 2.4. Budget for nutrition service delivery 2.5. Specific arrangements at local, provincial and national level	2. Management & Support services
3.1. Delivery of sub components of nutrition through HFs 3.2. Supplies and commodities 3.3. Nutrition program vs. other programmes 3.4. Information, Education & Communication 3.5. Barriers to nutrition service delivery 3.6. Quality of Services	3. Service delivery
4.1. Complementary projects to BPHS 4.2. Pilot projects	4. Exposure to additional support/interventions to filling gap
5.1. Awareness on policies 5.2. Revision to the policies 5.3. Planning, Monitoring, and Evaluation	5. Policy, Monitoring and Evaluation mechanisms

7. RESULTS

The themes drawn from the interviews have been outlined in this section. This has been part of the agreed thematic content analysis approach and the findings have been in line with the set objectives. Adequately answering the research question, this section covers the perception of all participants into the following main themes:

1. Training and capacity development
2. Management and support services

3. Service delivery
4. Exposure to interventions
5. Policy, planning, monitoring and evaluation mechanisms

7.1 Staffing, training and capacity development

7.1.1 Staffing

Most of the participants agreed there were no dedicated staffs at BPHS facilities to implement nutrition component as part of the BPHS key element.

Almost all participants stated that however there are other staff who are assigned to look after the nutrition but in many facilities where the patients load is heavy, those staff are already overloaded in providing other services. As a result, the nutrition services could not be effectively offered through BPHS and EPHS health facilities. It was widely stated that nutrition requires more efforts and the existing staff either cannot perform their tasks adequately or do not have the capacity to look after the nutrition component because they are not sufficiently trained, as was highlighted by few participants.

Few participants highlighted that some organizations getting support for BPHS from sources other than GCMU (PCH, SEHAT etc.) they hired some nutrition staff in the DH and CHC levels to work on nutrition component.

The observation and clinical records showed that all health facilities were fully staffed as per the BPHS guidelines. This is because all of the visited health facilities were located in urban areas where staff shortage is not an issue. Thus it cannot represent all health facilities of Afghanistan.

The observation of health service delivery and HMIS records corroborated that due to load of patients and unavailability of dedicated staff for nutrition especially in BHCs, some CHCs and even some DHs, the nutrition service delivery could not be provided in the same manner as reproductive health and immunisation services are provided.

7.1.2 Training and capacity building

The observation and review of records confirmed that apart from lack of staff majority of the health facilities visited did not have a consistent and continued programme for training them. Only few health facilities had around 50% of their staff (medical doctors, midwifes, nurses) trained. These staff received trainings on various nutrition-related topics i.e. Community Management of Acute Malnutrition (CMAM) Infant Young Child Feeding (IYCF), Breastfeeding (BF), Exclusive Breast Feeding (EBF), Complementary Feeding, and Behavioural Change Communication (BCC) through initial and refresher trainings. They stated the trained staffs were capable of providing cutting-edge evidence based services to population. One of the participants said that any trainings conducted for them have significantly changed the practice among facility staff in the way of measuring and presenting malnutrition.

It was found that health workers especially those who did not undergo trainings had limited knowledge about nutrition topics due to the unavailability of assisting tools for improving health workers knowledge and performance. In few health facilities where the guidelines were available, staff could not read them because they don't get time to read these guidelines having more than 50 to 100 pages.

While the overall perception at central level is that BPHS NGO should be actively involved in the capacity building of Provincial departments of MoPH, the perception in the field, it is opposite. In at least two of the provinces, representatives of the BPHS NGOs expected Provincial Public Health Office (PPHO) and Provincial Nutrition Officer (PNO) to provide support which PNO could not do.

Most of the PNOs and NGOs provincial staffs were aware of the 21-day TOT training that was conducted in Kabul two years back and mainly the PNOs and the NGO Nutrition focal points or master trainers attended it. Most of them acknowledged that valid criteria were set for selection of participants for the TOT participation. However, in half of the provinces, the persons who had got TOT training had either left the province or were transferred to a less relevant position.

As per review of the records, the training was more or less cascaded at the provincial level in some provinces but due to lack of resources and availability of enough trainers a full package was rarely cascaded to provincial and facility staff by the master trainers. When asked whether they have put forward a proposal for seeking funds from PPHO or Central MoPH, the answer was negative. In provinces where training was cascaded, it was provided at interval of three to five days

Few of the participants acknowledged that at least 50% of their staff have been trained on establishment of Therapeutic Feeding Unit (TFU) and Outpatient Therapeutic Program (OTP) as a result of the 21-day TOT that was provided about two years back.

One of the bottlenecks that was found with regards to training of staff was the staff turnover. Participants believed that if the MoPH and organizations manage to offer trainings to all staff of health facilities, the impact of the turnover would be less significant.

Many participants specifically mentioned that the MoPH through PND should arrange trainings and seminars for the capacity building of NGO staff and should arrange materials for nutrition at national level. It was emphasized that NGO staff targeted by these training should be ones who are involved in the monitoring, supervision and delivery of nutrition services.

A significant number of other participants stated that MoPH and other organizations i.e. USAID, UNICEF, etc. are expected to train health personnel on malnutrition and its treatment.

Few participants suggested that CHWs should also be targeted by trainings so that health service delivery by CHWs is improved and referrals by them are increased.

Looking the training records with regards to nutrition service delivery, it was observed that no proper recording system exist at all levels –health facility, provincial and Kabul. Nor the HMIS was helpful to extract data reflecting how many staff are trained in certain categories of health facilities (BHC, CHC, DH, etc.) in each province.

7.2 Management and support services

In all provinces, the participants stated that the Public Nutrition Department (PND) has emerged as one of the strongest departments within MoPH in terms of having sound leadership, qualified staff and having great potentials toward improving nutrition service delivery. The study expert too observed that the department is staffed with qualified people. However, the participants did not feel they were enjoying sufficient support from PND. They were guessing that PND might be unable to provide extended support due to lack of resources with PND. This was also confirmed as a real bottleneck in meeting with PND staff at Kabul level.

7.2.1 Role of Provincial Nutrition Officer & Nutrition Focal Points of NGOs

In all provinces, there is a provincial PNO who has a term of reference (See Annex 4) to coordinate nutrition related activities at provincial level as well as to monitor nutrition component in BPHS health facility and train staff on nutrition topics. In few provinces, NGOs had named an officer as nutrition focal point but not in all provinces they had a specific TOR tailored for nutrition or the TOR was inadequate toward strengthening the nutrition component. In majority of the provinces, they were actually overseeing nutrition component as an additional responsibility (See Annex 5). At district level at BHC and CHC however there is rarely a nutrition focal point; only in few districts of one of the provinces (Guzara, Pashtun Zarghoon, Obi districts of Herat Province) nutritional focal points exist per district who follow the same TOR as the PNO. At facility level the nutrition service delivery task has been assigned to a nurse or midwife as an additional task.

A substantial number of participants were not satisfied with the assistance provided by PNOs. Even one of the participants (P12) did not know whether any PNO existed at provincial level. Only one participant (P7) stated s/he was feeling fine with the PNO. Few participants highlighted that a province which have more than 100 health facilities and those having only 30-50 HFs each have a single PNO which is not fair.

Most of the PNOs admitted that due to large number of health facilities it was impossible for a single PNO to visit every health facility as desired.

In addition PNOs had movement restrictions to insecure areas. These problems were more pronounced for female PNO. Few participants stated their functionality is also restricted due to lack of resources (lack transportation facility, staff and budget). As a result; HFs did not receive enough monitoring of nutrition component in the BPHS.

All participants from NGOs expected a lot of technical support from the PNOs while PNOs expressed its insufficiency in meeting up their needs. They acknowledged that PNOs do not have enough capacity for supporting the nutrition programme. This lack of capacity is in terms of insufficient resources, insufficient individual technical and managerial capacity and insufficient staffing. They stated PNOs will be effective only if they are provided sufficient resources, staff and transportation so that they could supervise health facilities and nutrition related programmes properly.

One participant (P11) stated that the reason why the support of PNO is not sufficient is limited follow-up and supervision by the Public Nutrition Department (PND) in Kabul. The participant went on and stated that PND should conduct training needs assessment through the relevant PNOs and develop the national capacity building programmes accordingly.

Two participants stated that the reason why PNO do not meet their needs is because they do not have proper monthly action plans for monitoring, and supervision. In addition, they do not have appropriate monitoring tools i.e. checklists and do not have a proper mechanism for providing feedback and reporting. Low level of the capacity of PNOs, lack of resources and numerous logistic problems were also cited as major problems why PNOs are unable deliver desired support.

7.2.2 Role of Provincial Public Health Director

Majority of the participants stated that PPHD does not pay the same attention to strengthening nutrition component as it does to other components such as EPI or other areas. When asked about the reason, it was revealed that since nutrition is an under-funded programme having less resources, budget, etc., the PPHD has no interest in it. This fact surfaced when one of the PNOs stated that PNO was not part of the proposal review process of the BPHS and EPHS applications. This is while PPHD was a voting member of the panel and he or she had to express her reservations if s/he thought the proposal was non-responsive to providing effective nutrition service delivery.

7.2.3 Coordination mechanism for nutrition service delivery

In all provinces, there was a nutrition coordination committee attended by MoPH, NGOs, UNICEF, education department, municipality, Rural Rehabilitation & Development (RRD), and women affairs but the meetings were less frequent (only less than three to four meetings per year) and the issues discussed were not adequately related to strengthening nutrition component of BPHS/EPHS. In one of the provinces UNICEF convened nutrition cluster meeting on quarterly basis. Reviewing the minutes of some of these meetings, the main issues of discussion were related to monitoring and supervision of private sector food industries, and sharing information of the relevant organization's intervention so that gaps are addressed and overlaps are avoided.

Few participants highlighted there is sometimes lack of coordination between different stakeholders; some organizations implement nutrition vertically without coordination with BPHS implementers; they should implement the programmes through the BPHS implementers.

7.2.4 Budget for nutrition service delivery

Both the PNOs and the NGO related nutrition focal points highlighted there was no specific budget available for strengthening nutrition service delivery. They stated there is budget available as a whole for the BPHS implementation however there is no earmarked budget for nutrition component. No access was received so that the financial documents could be reviewed.

Some of the nutrition programmes are vertically supported by UNICEF, WHO or through Canada-DFATD but there is limited information available with PNOs about the details of budget for nutrition component. The facility staffs are not aware at all about allocation of funds for nutrition component.

Few participants suggested that allocating separate budget line for nutrition service delivery at health facility level would be highly effective.

Few participants (especially PNOs) stated that organizations funding other inventions i.e. UNICEF, WFP, etc. should share the budgetary issues with PNOs so that any possible duplication could be avoided and required assistance could be provided accordingly.

7.2.5 Specific arrangements at local, provincial and national level

Some participants appreciated that nutrition has recently gotten attention due to the fact that PND's leadership has been strengthened and the department is staffed with competent nutrition experts. In addition, a PNO has been recruited in each province and each BPHS implementing NGO has a focal point for nutrition component. It was acknowledged there are some guidelines at each health facility for enrolment discharge and referral, in the nutrition component. However, the participant fell short of naming the exact guidelines in this regard or they could be provided during the visit. Few other participants stated that nutrition management at clinic, provincial and national levels is sub-optimal and insufficient. They stated mobilizing mobile health teams for nutrition service delivery would ensure the services are delivered to the doorstep of the homes of beneficiaries.

Some facility managers also acknowledge that their nutrition programme gets monitored by officials from PPHO and MoPH and that nutrition is getting expanded to more and more districts but they thought that only monitoring was not effective and there should be equipment and more supplies to be distributed to mothers.

7.3 Service Delivery

7.3.1 Delivery of sub components of nutrition through HFs

Corroborated by observation and HF records, some components of nutrition i.e. food demonstration, community assessment, surveillance system could not be implemented in all health facilities (except DH, and some CHCs where these services including Therapeutic Feeding were offered). These services are included in BPHS and are expected to be delivered by DH, CHCs, BHCs, SCs and HPs (See Table 8). The reason was cited as lack of staff, lack of resources and budget. Screening dubbed as 'Growth Monitoring' by HF staff is reported to be implemented in all health facilities but it was argued that it involved a lot of physical work while the current staffs were already busy with other jobs. Even, in one of the visited health facilities, the guard was assigned to conduct screening. The head of clinic claimed the guard was trained on this.

Reviewing the HMIS records, it was revealed that the current Health Management Information System (HMIS) cannot capture data about the provision of all sub components of nutrition. Currently, the HMIS captures information only about screening, treatment of malnutrition.

The table below provides information how the health facilities are performing in terms of delivering each component of nutrition outlined in the BPHS. According to the table below, only district hospitals are doing well in terms of providing all sub components. The visited CHCs and BHCs are not doing well in delivering optimised nutrition services. The major reasons cited were shortage of staff, unavailability of trained staff, lack of specific budget for nutrition and external support, and unavailability of standard operating procedures:

TABLE 8: SUB COMPONENTS OF NUTRITION IN THE VISITED HEALTH FACILITIES

Activities mentioned in the BPHS	Health Facilities Visited			Remarks
	DH	CHC	BHC	
A. Assessment of malnutrition (population level)	No	No	No	
B. Prevention of Malnutrition				
B1. Vitamin A supplementation to all children 6 months to 59 months	Yes	Yes	Yes	
B2. Promotion of Iodized Salt	Yes	Yes	Yes	
B3. Promotion of Balanced Micronutrients rich food	Yes	Yes	Yes	
B4. Support and promote Exclusive Breastfeeding	Yes	Yes	Yes	
B6. Promotion of complementary feeding	Yes	Yes	Yes	
B7. Community food demonstration	Yes	No	No	
B8. Iron Folic Acid supplementation	Yes	Yes	Yes	
B9. Promotion of maternal nutrition	Yes	Yes	Yes	
B10. Underlying causes of malnutrition	Yes	No	No	
C. Treatment of malnutrition				
C1.Micronutrient deficiency disorders	Yes	No	No	
C2. Outpatient treatment of SAM	Yes	No	No	
C3. In-patient treatment of SAM	Yes	No	No	
D. Surveillance and Referral	No	No	No	
D1. Clinical-based surveillance	No	No	No	
D2. Screening and referral	Yes	Yes	Yes	
D3. Reporting	Yes	Yes	Yes	

TABLE 9: MONTHLY AVERAGE OF HMIS IN HEALTH FACILITIES VISITED

Indicator	Kabul		Ningarhar		Parwan		Baghlan			Saripul		Herat	
	DH	CHC	DH	BHC	CHC	BHC	DH	CHC	BHC	CHC	BHC	DH	CHC
Vacant positions	0	4	0	0	0	0	0	0	0	0	0	0	0
Antenatal Care	823	691	135	75	197	55	111	150	45	167	64	148	235
Postnatal Care	412	NA	215	45	23	6	404	68	35	35	36	234	43
Family Planning	600	NA	216	50	23	0	143	83	5	43	38	236	45
Number of children attended	3200	494	250 0	700	638	600	2000	505	400	640	700	2800	638
Childre screened for malnutrition	2000	3	223 5	560	30	500	1947	505	352	640	600	2340	638
Treated for malnutrition	15	3	6	0	0	0	26	0	0	0	0	25	0

7.3.2 Supplies and commodities

In one of the provinces, it was cited that there was serious problems with regards to the supply of nutrition commodities (chiefly related to UNICEF and WHO) and highlighted that most of the times, they receive near-expire commodities which could not be used with the given period. Most of the participants stated the materials should be supplied on time and the supply system should be improved.

Reviewing the stock of health facilities, it was corroborated that at least two of the health facilities the stock out of iron and folic had been observed for a period of about one week for the last six months. However, during the visit of these health facilities no stock-out was observed.

7.3.3 Nutrition programme vs. other programmes i.e. EPI, T.B.

Most of the participants agree that EPI and TB are more successful than nutrition. Majority of them stated the reason behind this fact is because there is more publicity and overall commitment for EPI while for nutrition, limited attention is offered. Most of the participants stated that EPI is an old programme and have dedicated staff funded by multiple sources at every level. Implementation of the outreach programmes, trainings and seminars for EPI was cited other major success factors.

Other reasons cited by few other participants for the poor performance of nutrition component included: low level of commitment from PPHD, lack of staff in PPHO dedicate for monitoring and supporting the nutrition activities, and lack of required resources for implementation.

7.3.4 Information, education & communication about nutrition

Most of the clients (around 70%) who were part of the focus group discussions had correct information about some key messages (i.e. exclusively breastfeeding, complementary feeding) related to nutrition. Their main source of receiving messages was cited as the staff of health facilities. However they fell short of defining some key terms related to malnutrition i.e. stunting, malnutrition, etc. The fact that the study was conducted in urban areas where population is relatively literate could be a limitation of the study because in rural areas, population may not have the same level of public awareness.

All participants agreed that the reason for which they are not doing well in nutrition component is limited mobilization of mass media highlighting the importance of this component so that attention could be garnered for strengthening nutrition service delivery.

Most of the participants mentioned there were health education programmes (group health education programme and counselling by midwives) on all health topics including nutrition topics that are provided to clients. But some of the programmes provide health education exclusively at the time of entry while the clients wait to get other health services. Some however have integrated health education and nutrition education into the other health services; vaccinators, midwives and doctors and nurses all provide health education to mothers.

Most of organizations provide conventional health education using posters and IEC materials that have been recommended by IEC department; but few (particularly in DHs) also do some behaviour change communication by demonstrating which and how to cook healthy food in order to keep children healthy.

A few participants highlighted that health education should not only be done through health facilities but mass media should also be involved for public awareness on nutrition.

Observation also revealed that, as per the schedule of health facilities visited, at least one session per week had been allocated for group health education in health facilities. In addition, it was also observed that midwife and medical doctor was doing counselling and health education to few patients in an amicable manner.

7.3.5 Barriers to nutrition service delivery

In almost all of the focus group discussions, some clients stated that bad behaviour of some health facility staff, being unwelcomed by staff in HF, long waiting times and lack of privacy inside the health facilities were significant hindrance factors in receiving health services.

This was also observed that in at least one of the health facilities, a male health worker was even physically harassing some female clients who were in the waiting hall.

Most of the participants mentioned lack of dedicated nutrition staff, and lack of nutrition supplies, as barriers for families to get nutrition services for their children. One participant said that some families even do not let their women visit a health facility.

It was stated by few informants that some families cannot stay for long time at the hospital with their children as they have many other responsibilities at home. For some families it is difficult to go to other facility when they are referred to take the child to a facility equipped with OTP or TFU. Lack of awareness and security-related issues were mentioned as other barriers for families to receive nutrition services from the facility.

Not having sufficient female staff was cited as another barrier at facility level for service delivery to children as well as the fact that the clinic cannot check all children due to the efforts needed by the staff to perform all nutrition measurements for malnourished children. Some informants also mentioned lack of space for providing nutrition services is an obstacle.

7.3.6 Quality of services

One of the participants highlighted the fact that the Quality Assurance (QA) standards do not adequately address nutrition component, QA standards should be revised accordingly. For example, monitoring and reporting areas need significant improvement, stated by few participants.

Majority of the participant suggested that allocating adequate budget and extra personal could be highly effective in improving quality of the nutrition component of BPHS and EPHS.

On the other hand, almost half of the informants of the study stated that one of the reasons for poor nutrition service delivery was lack of user-friendly standard operating procedures (SOPs) and guidelines. They suggested that SOPs and guidelines need to be developed by the MoPH and be used in health facilities for nutrition service delivery.

A few other participants stated that improving infrastructure and availability of enough space for provision of nutrition services was another important measure for providing nutrition services through BPHS and EPHS.

Reviewing the quality assurance standards toolkit, it was corroborated that nutrition element has received very little attention. In addition, it was also observed that SOPs for nutrition service delivery did not exist for the use of health workers.

7.4 Exposure to interventions

7.4.1 Complementary projects to BPHS

While the interventions by other organizations such as WHO, WFP, UNICEF, Canada-DFATD and other implementing partners, such as, SFP, IMAM were welcomed by most of the participants, there were few participants who did not share the same opinion. One PNO stated that the nutrition interventions by other organizations under the current arrangement are counter-productive and claimed they disrupt the current BPHS service delivery. S/he complained that some additional emergency driven projects by UNICEF, WFP, WHO and others which are implemented in short intervals are not properly coordinated with the Provincial Public Health Office and Provincial Nutrition Officer. One of the PNOs went on that the implementation of additional projects related to strengthening nutrition service delivery should be managed by MoPH as assigning the same NGO for the implementation does not give the desired results. It was recommended that all interventions from other organizations i.e. UNICEF, WHO, etc. are at least implemented in coordination with Provincial Public Health Office and PNO should have key role in administering these interventions

The majority of participants stated that in facilities where, with the help of other organizations, CMAM support is implemented they have all the necessary equipment and supplies for providing a comprehensive package of nutrition services. However in facilities where there is no additional programme for filling gap in nutrition service delivery they are unable to provide a full range of nutrition services; they rather provide screening and referral to other facilities.

One of the PNO stated the nutrition service delivery could be interrupted if these vertical projects are stopped but over a period of time, the situation could be back to normal.

Few participants feel that nutrition is not given enough attention by the donors as is given to most other components of BPHS.

7.4.2 Pilot projects

One participant suggested that MoPH should have proper coordination and control all pilot projects as the MoPH should assess whether these pilot projects genuinely help in strengthening nutrition component or not.

7.5 Policy, planning, monitoring and evaluation

7.5.1 Awareness about policies

Almost half of the participants either did not have any opinion about nutrition related policies and strategies or could not give precise opinion about their revision. The given two situations strongly suggested they were not adequately aware of the policies and strategies.

One of the participants stated the real problem does not lie with the policies, yet the real issue is their implementation. However, the participant admitted that lack of staff was a major restricting factor in their implementation.

On observation, it was revealed that in most of the visited health facilities, copies of the policies and strategies did not exist and the staff of health facilities did not remember they have read them at least once.

7.5.2 Revision of the policies

Most of the participants recommended that the policies should allow recruiting more staff so that the nutrition service delivery could be taken care of at all levels of health facilities including district hospital. This need was more pronounced in BHCs or lower tier health facilities which already have limited staff.

One of the participant mentioned that composition of iron folic acid was not standard and the policy is not clear about that. Few other participants also highlighted the need for sharing policy and strategy documents with all levels of staff engaged in nutrition service delivery.

One participant (P13) highlighted a gap in gestational age criteria for pregnant women for inclusion in the nutrition programme. For example a guideline mentioned that pregnant women of four month gestation should be enrolled; this criteria is difficult to meet as diagnosing pregnancy at this stage is a bit difficult. In the past pregnant women were enrolled to nutrition program from month six until three months after delivery. However, the participant did not mention the exact name of the document where this gap exists.

Another informant suggested that operationalizing surveillance system in all health facilities will give positive results toward improving nutrition component in BPHS and EPHS. Few others suggested that more focus should be placed on children and the coordination between all units within a health facility should be strengthened. Not only qualified staff do need to be hired but there should be an extensive capacity building programme for the staff of health facilities directly involved in nutrition service delivery. In addition, they need to be trained on guidelines and policies related to nutrition. Few others acknowledged the role of communities, elders and religious leaders in promoting awareness about nutrition.

Providing incentives to CHWs in lieu of referring malnutrition cases to health facilities was another crucial recommendation by few participants.

7.5.3 Planning, monitoring & supervision from nutrition service delivery

One of the participant suggested that whenever MoPH receives a proposal from an organization that should undergo a review by the nutrition specialists from PND and PNO to ensure that the proposals are responsive from nutrition point of view.

Few participants suggested that MoPH should have a proper mechanism for regular supervision from provincial level activities and then PNO should have a regular mechanism for the monitoring of the activities of NGOs and health facility activities. They stated that for monitoring nutrition activities, a separate checklist should be developed and used.

One of the participants (P22) mentioned that donors might conduct studies aimed at identifying challenges and problems. In the view of these studies, donations should be provided accordingly.

P22: Evaluation and surveys should be conducted in every aspect of nutrition that problems could be explored in nutrition section and then accordingly solutions could be sought

Reviewing the supervisor log books of the visited health facilities, it was revealed that no single visit has been paid to health facility for the purpose of providing supervisory support specifically for improving the nutrition service delivery. There was no detailed feedback available with regards to the nutrition service delivery in each health facility.

8. Discussion, Conclusion & Recommendations

This chapter addresses the implications of these findings, highlights strengths and weaknesses of the study as well as lessons learned. The recommendations for next steps are an integral part of this chapter.

8.1 Implications of the main findings

8.1.1 Staffing, training and capacity development

In this study it was found that insufficiency in staffing was not confined to health service delivery. There is rather an extensive need that the staffing pattern for nutrition service delivery and monitoring should be expanded both at provincial and service delivery level. For example, it makes little sense that the PNOs are equally distributed among all provinces. Meanwhile, we expect health facilities where there is no one to take care of coordinating the nutrition service delivery through health facilities. This is in stark contrast with the current practice of the Ministry of Public Health which manages service delivery through only one poorly supported PNO responsible for monitoring the nutrition component of BPHS across the country with no dedicated staff for nutrition services delivery at health facility level.

With regards to training and capacity, it was revealed that there is no consistent and systematic approach for trainings and the capacity building of staff involved in the management of the nutrition programme in Afghanistan. Only few provinces did not have more than 50% staff (nurses, midwifes, and medical doctors) trained in the nutrition component. However, what Canada-DFATD is doing in connection to trainings for health staff (Canada DFATD, 2014) is completely aligned with the findings of the study revealed with regards to the need for trainings. Canada DFATD is working with the MoPH and locally selected BPHS NGOs to address maternal, new-born and child nutrition through the following:

1. Capacity building of staff and community based workers (at provincial, health facility, and community levels).
2. Supporting MoPH in integrating the management of acute malnutrition within health facilities role, as part of the national Integrated Management of Childhood Illness (IMCI) programme

Through a different modality, Canada DFATD also implement the following interventions aimed at improving maternal and under-five nutrition and child health:

1. Nutrition promotion through strengthening existing community structures,
2. Promoting optimal IYC through CHWs and FHAGs,
3. Improving the coverage of micronutrients through BPHS NGOs
4. Managing Severe Acute Malnutrition
5. Capacity building of staff for nutrition service delivery.

8.1.2 Management and support Services

According to this study, management and support services for the delivery, supervision and monitoring of nutrition component through BPHS and EPHS health facilities is poorly resourced and insufficient. The study found that the PNOs in all provinces had very minimal role in supporting the nutrition

component of BPHS and EPHS. Provincial Public Health Director was not found vigilant about strengthening the nutrition component. And the BPHS implementing NGOs had not properly budgeted for the provision of nutrition services as desired. Therefore, there was a perceived need for strengthening the technical and managerial capacity of PPHOs and BPHS NGOs so that nutrition service delivery could be improved.

According to the Fact Sheet of Nutrition Programme in Afghanistan (USAID, n.d.), UNICEF aims to improve the nutrition of the population through its direct involvement in nutrition service delivery as part of the emergency programme chiefly through providing commodities and only limited attention is paid to reinforcing the institutional capacities of the Provincial Public Health Office and BPHS implementing NGOs. What Canada-DFATD is doing in Saripul and Herat provinces were contributing to somehow fixing the same situation. The support of the Canada-DFATD was not only aimed at strengthening service delivery but also providing technical and managerial support to both PPHO and NGO. This could be replicated as an effective model to other provinces.

8.1.3 Service delivery

In most of the health facilities, nutrition component is not fully offered. This is not only due to the weakness at managerial and health facility level but also mirror a weakness and vagueness in the policies and strategies which have been developed on solitary basis without effectively involving field-based service providers in their development. For example, while community assessment of nutrition, community food demonstration at health facilities, and surveillance system for nutrition are included in the BPHS policy as the mandatory sub-components of nutrition but the health facility staff and supervisors have no consistent idea how these elements how they could be offered.

In addition, the study found that as compared to other programmes i.e. immunisation, the nutrition component does not receive the same level of attention. It was widely believed that if nutrition component receive only a fraction of the attention which is offered to immunisation the nutrition service delivery quality will be significantly improved.

8.1.4 Exposure to interventions

Exposure to interventions was something that was widely welcomed by almost all participants. However, in some areas, there was some degree of disagreement about the way these interventions had to be administered. The main areas in which needs were perceived by the participants were the following:

- Offering trainings to staff
- Institutional capacity building
- Providing commodities
- Pilot projects
- Financial support for generating more evidence by conducting studies

8.1.5 Policy, monitoring and evaluation

The study found the following two serious problems with regards to the awareness about policies and strategies that have been developed by the MoPH:

1. The policies have been developed with the limited involvement of field-based health service providers
2. There was an extensive unawareness about the related policies and strategies. Not only health service providers did not know about these policies

This situation warrants the need for the revision of policies and strategies with the extensive involvement of all levels of staff. In addition, there is desperate need that adequate advocacy and awareness is done about them.

8.2 Review of the research process: Strengths, limitations of the study and lessons learned

8.2.1 Research design

According to Green and Thorogood (2004), an exploratory qualitative design triangulated by observation was a strength because this was the most effective way for testing the perception of interviewees with regards to the issue. As a result, a firm understanding on the issue could be established**.** Alternatively, other designs such as quantitative methods (correlation, meta-analysis, etc.) are not applicable or would prove less effective because there would have been less opportunity for exploring facts around the issue and the findings would have had less potential for generalizability.

The fact that IDIs constituted a substantial part of the methodology of this study is a notable strength. IDIs allowed the researcher to dig into the viewpoints of participants to explore topics in-depth and reveal new knowledge about the settings where the study is conducted (Green and Thorogood, 2004),

A value added to the strength of the methodology is attributed to the fact that both researcher and participants shared similar socio-cultural traits putting the researcher in a position to exercise good skills in social interaction with participants. The fact that researcher had deep understanding of the traditions, culture and characteristics of the geographical areas where the study was conducted is considered another genuine strength of the study as positionality is a central element of any qualitative research (Ganga & Scott, 2006).

The researcher overcame to extract the viewpoints of all participants amicably in an open atmosphere. The researcher and participants shared the same language and thus there was no need for translation. Minimizing interference in the flow of the interview and making probing effective, this fact effectively avoided any misleading interpretation as foreseen by Green and Thorogood (2004).

Nevertheless, the influence of a male researcher interviewing a female respondent in a traditional society like Afghanistan is acknowledged as a limitation of this study. Moreover, the influence of an outsider (originating from another province) could have also been a limitation.

Apart from that, limitations in non-verbal communication especially with female respondents could also be acknowledged in this study. The reasons was that per traditional obligation the male researcher had to keep a distance from the female respondent and female respondent could not maintain a face to face eye contact with the male researcher due to cultural limitations where there is full segregation between men and women in social life.

The fact that the researcher had a similar background and working experience with that of health programme managers and health service providers who were interviewed, may have created potential bias towards the findings chiefly because of the researcher's curiosity about the issue. This simply meant that the researcher positionality had a significant influence throughout the study, even though self-reflexivity was used to mitigate these issues. The researcher did not have any issue with regards to any types of bias including recall.

TCA was used because only one person (one Study Expert) was mainly involved in conducting the research–data collection, transcript development, analysis. The analysis in this case is chiefly based on synthesis which leads to building theories as part of a theoretical analysis starting from individual experiences toward more conceptual elements about the topic. This was simply deemed not feasible for this study due to time and resource constraints (Green and Thorogood, 2009).

As Afghanistan is a traditional society, it is not easy to find women to be interviewed by a male. This became further difficult when they were asked that their voice would be digitally recorded. That is why the sample of female participants is comparably smaller and is a limitation of the study.

As stated by Lisa et al, (n.d.) to make sure the findings of a research reflect a true situation and are certain in nature, triangulation is required. Through this researcher was compelled to adopt consistency in data sources, make observations, review documents and use structured questionnaires

(See the Annexes) in undertaking the study. The triangulation effectively addressed data collection, investigator, theory, methodologies and environment where the study took place. Nevertheless the fact that various category of people (healthcare providers and nutrition programme managers) were interviewed is a notable strength of the study because it represented a variety of insights.

8.2.2 Rigour

According to Litva and Jacoby (2002), rigour in qualitative research means that the study findings are sufficiently credible, have enough potential not only for transferability but also for dependability and conformability. As stated by Green and Thorogood (2009), rigour could be maintained through reflexivity in qualitative researches which lead to credible and authentic accounts of the phenomenon under discussion.

A systematic step-wise approach has been followed to ensure rigour of analysis. First, the role of researcher as being part of the process aimed at producing data and their interpretation was well-recognized. The fact that the researcher and participants shared the same language and most of the data received were accurately noted and full scripts were made including translations to the English language for cross-check and quality assurance purpose indicated that reliability of the research findings was strictly secured. The fact that the research was conducted by one person –same researcher-, itself was an important measure for ensuring reliability (Green and Thorogood, 2004). However, that only one person coded the material is a limitation.

Another limitation was that a validity check as advised by Green and Thorogood, 2004) could not be performed due to shortage of time. Through this, it would have been possible that the research findings were taken back to participants and a consensus was made on the outcomes.

8.2.3 Lessons learned

A research of qualitative type was a favourable choice to complement the available insights about gender related factors in accessing healthcare services. It facilitated establishing a good linkage between the knowledge and local context. Exploring the perception of participants as part of a social constructionist viewpoint has given further new insights on the topic.

The proposed study has highly been instrumental in further enriching existing information with regards strengthening nutrition component in BPHS and EPHS. The researcher has used in-depth interviews with relatively few participants particularly the ratio of female participants has been lower than males.

The researcher has deemed thematic content analysis as an appropriate choice for this study. Alternatively, grounded theory could have been used which would then have required more resources, time and additional researchers. With the grounded theory analysis, the situation would have been explained more in-depth leading to a substantive theory about the situation. As stated by Leavy (2004), Grounded theory is highly effective in giving a good structure and arrangements for data collection and analysis. However, to have more comprehensive results, grounded theory would have been a better choice which could be taken into consideration in similar future studies. This is possible when there is enough time, for testing, analysis, and re-testing. (Green and Thorogood, 2009).

9. KEY RECCOMMENDATIONS

Staffing, training and capacity building

1. All current positions of PNOs should be announced and filled as part of a competitive process. Those who have desired level of performance could be retained.
2. Until additional nutrition staffs is approved, PND needs to work with the Human Resources Department of MoPH as well as NGOs to ensure the job description of all health facility staff be extensively revised and specific bullets be added so that the staffs feel themselves accountable to strengthening the nutrition component. GCMU can play an effective facilitation role in this regard.

3. There should be a consistent and continued programme for trainings and other capacity building activities at provincial level and national level capacity building based on a comprehensive needs assessment with extensive involvement of BPHS NGOs. PND should be empowered to train the trainers stationed at provincial level and then provincial level Master trainers from PPHO and BPHS NGO should be enabled to cascade trainings to health facility staff. The responsibility of initial trainings could be assigned to PND, however NGOs Master Trainers would be trained so they can cascade the trainings to the HF staff.

Management support

1. The TOR of the Provincial Nutrition Officers should be revised in a manner that the position holder give sufficient time to supporting nutrition component of BPHS and EPHS. The most important gap in the current TOR of PNO is it contains no responsibilities specifically related to strengthening the nutrition component of BPHS. Meanwhile, the TOR does not mandate PNO to be involved in monitoring BPHS NGOs to monitor their performance in nutrition service delivery.
2. To enhance the efficiency of PNOs, they should be assisted to have proper monthly action plans and have effective monitoring and supervision tools. PND should conduct follow-up and systematic appraisal of PNOs and who should be assisted to maintain a functioning system of follow-up and reporting to PND. PND could further explore options how the activities of all nutrition officers in all provinces could be effectively monitored and supervised. Categorisation of provinces into clusters and assigning officials within PND for taking care of each cluster of provinces could be an option.
3. To ensure enough budget is allocated for strengthening nutrition component; the opinion of Public Nutrition Department (PND) should always be solicited while reviewing the BPHS and EPHS proposals.
4. To avoid stock out of nutrition commodities, a centralised nutrition supply management needs to be in place. The approach of Performance-based Contracts for Health Services (PCH) with regards to pharmaceutical management could be replicated in this regard. The commodities mostly needed at all levels of health facilities are iron, folic acid, vitamin A, micronutrient supplementation, Mebendazole.

Service Delivery

1. As revealed by the study, poor infrastructure and limited space was cited a significant hindrance to nutrition service delivery. PND should check with the Engineering department to ensure that the need for nutrition service delivery is adequately considered in the standard design for constructing buildings of the health facilities. For short term impact, a rapid assessment of infrastructure gap should be to allocate enough budget for renovation and reconstruction.
2. To expand the provision of nutrition service delivery to community, the nutrition service delivery should be properly integrated into the mobile health team activities so that the services are provided both at health facility-based and community based. In addition, other outreach setups should be explored for the provision of nutrition service delivery.

Exposure to interventions

1. The interventions by WFP, UNICEF, etc. should be done in complete coordination with PPHO and BPHS staff. The approach of Canada DFATD in Saripul and Hirat could be replicated to other provinces. Working through the Provincial Public Health Office, its empowerment, and building the capacity of its staff has been noticed as an integral part of the Canada DFATD interventions for strengthening nutrition service delivery.
2. Before designing interventions for strengthening nutrition component, the issue of duplication and continuity of them should be strictly taken into consideration.
3. There should be national and provincial level steering mechanisms for coordination. The mechanism should be led by PND and PNOs to facilitate close coordination and cooperation between the various partners i.e. BPHS/SEHAT NGOs, donors, UN agencies that are involved

in implementing nutrition programmes. The terms of reference of this coordination committee should be developed in consultation with all involved stakeholders.

Planning, Policy, Monitoring, and Evaluation

1. As observed in the current structure of MoPH, the Public Nutrition Department comes under the General Director of Primary Health Care (PHC) and Preventive Medicine. The fact that improving nutrition of the population need corporate efforts which are not limited to MoPH, the department should be placed in the organogram in a manner that it could easily establish coordination with other sectors i.e. Rural Rehabilitation, Urban Development, Industries, etc. under the oversight of the Leadership of the Ministry of Public Health. This will also enable PND to implement the Nutrition Action Framework (NAF) which developed in 2012 and involving many other sector ministries.
2. To fix the unfair posting of PNOs, provinces should be categorised based on the number of health facilities. Considering the budgetary restriction, there should be an assigned nutrition officer to take of the health facilities in a district. There could be up to 2-3 provincial nutrition supervisors in each province working under the oversight of PNO having a clear scope of work for supervising the nutrition component in BPHS/EPHS health facilities.
3. Quality Assurance standards as well as the available Standard Operating Procedures should be developed and/or revised in a manner that they should adequately address the nutrition component.
4. MoPH needs to conduct further researches and studies. One of the areas which needs to be explored is to determine the current cost per capita for nutrition service delivery and have it compared with the desired cost per capita and then make investment on strengthening nutrition component accordingly.
5. The Afghan HMIS system needs to be revisited. It should be ensured that it capture necessary data about performance in nutrition service delivery.
6. The issue of gender mainstreaming should be adequately considered in the planning, provision of services and capacity building related to nutrition service delivery.
7. The current guidelines are very lengthy (100-200 pages) and as a result staff do not have time to read all them. To ensure the guidelines are implemented properly, SOPs need to be translated so that health facility staff can offer all required nutrition services step-by-step.

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ANNEXES

1. Interview Guide and Questionnaires
2. Participants' Informed Consent form
3. Comparison analysis of Herat and Saripul
4. PNO's terms of reference
5. Job description of NGO Nutrition Supervisor
6. Participants' quotes

ANNEX 1. INTERVIEW GUIDE AND QUESTIONNAIRES

INTERVIEW SCHEDULE

Assignment: Assessment of nutrition interventions in the BPHS and EPHS health facilities in Afghanistan

INTERVIEW DETAIL

Participant Code #: Site: Day: Date:

Interview start time: Interview end time:

PARTICIPANT INFORMATION

- Male:
- Female:
- Age [age bracket]:
- Occupation:
- Organization [for organization respondents only]:
- [Note if the respondent is representing an NGO, MoPH, community or private clinic]
  - Position/job title
  - Years in service

LEVEL OF NUTRITION COMPONENT IMPLEMENTATION

Staff

1. Is your health facility adequately staffed? What is your opinion about the sufficiency of staff. If they are not sufficient then what are the reasons? [*Probe: do you think the current staffing level at BPHS is adequate;. If more staff are needed, what are your reasons*?]
2. What is the current capacity of your organization and staff in providing nutrition services to mothers and children?

IEC

3. How is health education/counselling conducted in health facilities? [Probe for: have BCC materials been developed/adapted for nutrition education and counselling by health service providers?, What are the key topics for the BCC on "good nutritional practices"?, To what extent health service providers are providing nutrition education and counselling to adolescents, pregnant and lactating women?]

Funds/Budget (Management Support Services)

4. Can you give information about the allocated budget/funds for nutrition services in your supported facility/facilities [*if asked from NGO representative or services provider*) / in your province [if asked from PNO].
5. Do you think programmes other than Nutrition, such as TB, EPI are more successful? If yes, explain what are success factors to be replicated for improving nutrition?
6. Overall, what do you think of the current management arrangement at national level/provincial level or health facility that are they adequate to deliver, monitor and supervise the nutrition interventions as specified in basic package of health services?
7. Are you aware of nutrition-related strategies and policies introduced by the Ministry of Public Health? Can you name them? [*Probe for: Do you think these policies are useful? If not, why they are not working?*]

Coordination

8. What kind of coordination mechanism to you have aimed at improving nutrition service delivery in your province? [Probe for: Do you have any provincial level coordination committee for coordinating activities related to nutrition in the province? If yes, how it is effective in improving nutrition component? If No, explain the reasons].
9. As per your understanding, how many other organizations are involved in nutrition service delivery programs; can you name them ? (WFP, UNICEF, Canada, etc.) . What is each stakeholder doing? [*Probe: What type of services do they offer? Are services offered by these organizations in coordination and harmony with the BPHS and EPHS service delivery?*

Supervision

10. Do you have 'nutrition supervisor' at provincial level and a nutrition focal point at health facility level? If yes, does he/she have a TOR and how s/he contributes to improving nutrition component? Is he trained? Can you share the Terms of Reference (TOR)?
11. If the interview is with PNO, then this question should be asked the following way:
    Do you have TOR? How do you contribute to improving nutrition component? Are you trained? Can you share your topics?
12. Do you think the contribution from PNO in improving nutrition component of BPHS is sufficient? Can you explain? (*Probe for: Did he or PND supervise HF, how often? TOR insufficiency/unavailability, resources, lack of coordination, lack of commitment, any other problem*?)

***Training*:**

13. How many staffs in your health facilities or office have received training pertaining to nutrition-related issues? [*Probe: initial/refresher for how long? do you believe the staff-members in your health facilities of office are capable of delivering/managing/supervising sufficient nutrition services? If yes, please explain. If no, what are the reasons?*]
14. Are you aware of the Training of Trainers (TOT) course organized by the Public Nutrition Department in Kabul? [*Probe: 1. How many persons have received TOT in your province and where are they now? 2. Who were introduced from your province? 3. And what criteria were used for introducing trainers for this TOT? 4. Do you think eligible candidates were introduced to this training*?]

The trainers were expected to cascade training to other health facility staff and community health workers,

15. How many other health staff were trained by these trainers as part of cascading about what they had learned in Kabul? [*Probe: Was this cascading effective? Can you describe? If this was not effective, can you explain their reasons? low capacity, low resources, lack of commitment of NGOs, etc*.]

BARRIERS AND GAPS IN PROVIDING OPTIMIZED NUTRITION SERVICE DELIVERY

Service Delivery

16. In your opinion, what problems your clients have in receiving nutrition services from your health facilities? [Probe for: Lack of awareness? Any access issue? Poor quality or unavailability of services through health facilities?]
17. What are problems, challenges, barriers and gaps in nutrition service delivery (especially to women and children) that you are aware of? [Probe for: Prompt: are there different kinds of barriers? What are these problems/gaps in general? What are these problems/gaps for children and women? Staff shortage, unavailability of equipment, behaviour of staff, etc.]

Policy

18. In your opinion, what are the gaps and problems with the current MOPH policies including BPHS and EPHS in relation to nutrition service delivery?

RECOMMENDATIONS FOR IMPROVEMENT

Policy

1. If you think the current polices need revision, what specific recommendations would you have?

Service Delivery

2. In your opinion what measures are required for enhancing nutrition component of BPHS and EPHS through health facilities?
3. What do you think about how the role of Provincial Nutrition Officer (PNO) could be improved? [*Probe for: Revising TOR, resources, coordination*]
4. What needs to be done to improve the capacity of your organisation and staff to deliver these kinds of services to women and children? Please be specific about the role of your organisation regarding these services – for instance, if relevant, what about monitoring implementation / planning services / reporting?
5. What are your recommendations with regards to nutrition service delivery programmes implemented by other organizations you mentioned?
6. Lastly, how can the government (ministry of public health) or any organization (USAID, UNICEF, WFP and Canada) improve provision of optimized nutrition services through BPHS and EPHS health facilities?

Interview with NGO Technical Manager

1. Specific to Nutrition in BPHS

Activities mentioned in the BPHS	Is it implemented in your province? (Y/N)	If Yes, Explain:	If yes, but not in a satisfactory level, what do you recommend? (specify to whom)	If No, Explain:	What do you recommend to implement this activity properly? (specify to whom)
A. Assessment of malnutrition (population level)	1-Yes 2- No 3- Don't know	What is the rate of SAM: Who did the Survey? ____ Were you involved? _r___ What was your role?		What are the key challenges/ barriers? _____	
B. Prevention of Malnutrition					
B1. Vitamin A supplementation to all children 6 months to 59 months	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B2. Promotion of Iodized Salt	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B3. Promotion of Balanced Micronutrients rich food	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B4. Support and promote Exclusive Breastfeeding	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B5. Growth Monitoring for < 2 years	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	

B6. Promotion of complementary feeding	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B7. Community food demonstration	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B8. Iron Folic Acid supplementation	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B9. Promotion of maternal nutrition	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B10. Underlying causes of malnutrition	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
C. Treatment of malnutrition					
C1. Micronutrient Deficiency Disorders	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
C2. Out patient treatment of SAM	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
C3. In-patient treatment of	1-Yes	How is done (name main		What are the key	

SAM	2- No 3- Don't know	components)? Who is doing? Any evidence of it? What is your role?		challenges/ barriers? _____	
C4. Out patient treatment of MAM (WFP is supporting this activity in 27 provinces, in severely food insecure districts, according to NRVA,	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
D. Surveillance and Referral					
D1. Clinical based surveillance	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
D2. Screening and referral	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
Reporting	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	

2. **Nutrition out of BPHS**: do you think that there are activities in nutrition necessary to be done, but they are not mentioned in BPHS, or they are not explicit and clear?
3. **Other programs examples**: do you have any example of other programs that you think are successful, and which components you recommend to incorporate in the nutrition to make it also successful?
4. Any other recommendation to improve nutrition services in the BPHS?

Interview with Head of Health facility

1. **Specific to Nutrition in BPHS:**

Activities mentioned in the BPHS	Is it implemented in your province? (Y/N)	If Yes, specify who is doing it in your HF?	If yes, but not in a satisfactory level, what do you recommend? (specify to whom)	If No, Who you think should do it?	What do you recommend to implement this activity properly? (specify to whom)
A. Assessment of malnutrition (population level)	1-Yes 2- No 3- Don't know				
B. Prevention of Malnutrition					
B1. Vitamin A supplementation to all children 6 months to 59 months	1-Yes 2- No 3- Don't know				
B2. Promotion of Iodized Salt	1-Yes 2- No 3- Don't know				
B3. Promotion of Balanced Micronutrients rich food	1-Yes 2- No 3- Don't know				
B4. Support and promote Exclusive Breastfeeding	1-Yes 2- No 3- Don't know				
B5. Growth Monitoring for < 2 years	1-Yes 2- No 3- Don't know				
B6. Promotion of complementary feeding	1-Yes 2- No 3- Don't know				
B7. Community food demonstration	1-Yes 2- No 3- Don't know				
B8. Iron Folic Acid supplementation	1-Yes 2- No 3- Don't know				
B9. Promotion of maternal	1-Yes				

nutrition	2- No 3- Don't know				
B10. Underlying causes of malnutrition	1-Yes 2- No 3- Don't know				
C. Treatment of malnutrition					
C1. Micronutrient Deficiency Disorders	1-Yes 2- No 3- Don't know				
C2. Out patient treatment of SAM	1-Yes 2- No 3- Don't know				
C3. In-patient treatment of SAM	1-Yes 2- No 3- Don't know				
C4. Out patient treatment of MAM (WFP is supporting this activity in 27 provinces, in severely food insecure districts, according to NRVA,	1-Yes 2- No 3- Don't know				
D. Surveillance and Referral					
D1. Clinical based surveillance	1-Yes 2- No 3- Don't know				
D2. Screening and referral	1-Yes 2- No 3- Don't know				
Reporting	1-Yes 2- No 3- Don't know				

2. **Provide us with the following data of your health facility for the last month: (*alternately you can ask each question from relevant staff*)**

Number and type of vacant position in your HF	Number of ANC, PNC, FP consultations	Number of < 5 children attended to your HF	Number of Children < 5 years screened for malnutrition	Number of Children treated for malnutrition

3. **Nutrition out of BPHS**: do you think that there are activities in nutrition necessary to be done, but they are not mentioned in BPHS, or they are not explicit and clear?
4. **Other programs examples**: do you have any example of other programs that you think are successful, and which components you recommend to incorporate in the nutrition to make it also successful?
5. Any other recommendation to improve nutrition services in the BPHS?

Interview with Health facilities Staff

Staff name/ position:

1. **Specific to Nutrition in BPHS**

Activities mentioned in the BPHS	Are you doing any activity as part of: (Y/N)	If Yes, Explain:	If yes, but not in a satisfactory level, what do you recommend? (specify to whom)	If No, Explain:	What do you recommend to implement this activity properly? (specify to whom)
A. Assessment of malnutrition (population level)	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
B. Prevention of Malnutrition					
B1. Vitamin A supplementation to all children 6 months to 59 months	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
B2. Promotion of Iodized Salt	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
B3. Promotion of Balanced Micronutrients rich food	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
B4. Support and promote Exclusive Breastfeeding	1-Yes 2- No	What do you do specifically? How?		What are the key challenges/ barriers?	

	3- Don't know	Do you have clear guideline for this? Do you feel confident in your work?		_____	
B5. Growth Monitoring for < 2 years	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
B6. Promotion of complementary feeding	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
B7. Community food demonstration	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
B8. Iron Folic Acid supplementation	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
B9. Promotion of maternal nutrition	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
B10. Underlying causes of malnutrition	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline		What are the key challenges/ barriers? _____	

		for this? Do you feel confident in your work?			
C. Treatment of malnutrition					
C1. Micronutrient Deficiency Disorders	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
C2. Out patient treatment of SAM	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
C3. In-patient treatment of SAM	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
C4. Out patient treatment of MAM (WFP is supporting this activity in 27 provinces, in severely food insecure districts, according to NRVA,	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
D. Surveillance and Referral					
D1. Clinical based surveillance	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	
D2. Screening and referral	1-Yes 2- No	What do you do specifically? How?		What are the key challenges/ barriers?	

	3- Don't know	Do you have clear guideline for this? Do you feel confident in your work?		_____	
Reporting	1-Yes 2- No 3- Don't know	What do you do specifically? How? Do you have clear guideline for this? Do you feel confident in your work?		What are the key challenges/ barriers? _____	

2. **Nutrition out of BPHS**: do you think that there are activities in nutrition necessary to be done, but they are not mentioned in BPHS, or they are not explicit and clear?
3. **Other programs examples**: do you have any example of other programs that you think are successful, and which components you recommend to incorporate in the nutrition to make it also successful?
4. Any other recommendation to improve nutrition services in the BPHS

Questionnaire for PPHO Staff

1. **Which organizations, other than BPHS implementers, are involved in nutrition activities of BPHS? Please name them and clarify their role as:**

Name of organizations	Funding sources	Their role

2. **Specific to Nutrition in BPHS**

Activities mentioned in the BPHS	Is it implemented in your province? (Y/N)	If Yes, Explain:	If yes, but not in a satisfactory level, what do you recommend? (specify to whom)	If No, Explain:	What do you recommend to implement this activity properly? (specify to whom)
A. Assessment of malnutrition (population level)	1-Yes 2- No 3- Don't know	What is the rate of SAM: Who did the Survey? ____ Were you involved? _r___ What was your role?		What are the key challenges/ barriers? _____	
B. Prevention of Malnutrition					
B1. Vitamin A supplementation to all children 6 months to 59 months	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B2. Promotion of Iodized Salt	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B3. Promotion of Balanced Micronutrients rich food	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B4. Support and promote Exclusive Breastfeeding	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	

B5. Growth Monitoring for < 2 years	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B6. Promotion of complementary feeding	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B7. Community food demonstration	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B8. Iron Folic Acid supplementation	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B9. Promotion of maternal nutrition	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
B10. Underlying causes of malnutrition	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
C. Treatment of malnutrition					
C1. Micronutrient Deficiency Disorders	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
C2. Out patient treatment	1-Yes	How is done (name main		What are the key	

of SAM	2- No 3- Don't know	components)? Who is doing? Any evidence of it? What is your role?		challenges/ barriers? _____	
C3. In-patient treatment of SAM	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
C4. Out patient treatment of MAM (WFP is supporting this activity in 27 provinces, in severely food insecure districts, according to NRVA,	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
D. Surveillance and Referral					
D1. Clinical based surveillance	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
D2. Screening and referral	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	
Reporting	1-Yes 2- No 3- Don't know	How is done (name main components)? Who is doing? Any evidence of it? What is your role?		What are the key challenges/ barriers? _____	

3. **Nutrition out of BPHS**: do you think that there are activities in nutrition necessary to be done, but they are not mentioned in BPHS, or they are not explicit and clear?
4. **Other programs examples**: do you have any example of other programs that you think are successful, and which components you recommend to incorporate in the nutrition to make it also successful?
5. Any other recommendation to improve nutrition services in the BPHS?

ANNEX 2. PARTICIPANTS' INFORMED CONSENT FORM

INFORMED CONSENT FORM FOR RESEARCH STUDIES

Title of Research Project: Assessment of Nutrition Interventions in BPHS and EPHS

Researcher(s): Qudratullah Nasrat

		Please initial box
1.	I confirm that I have read and have understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected.	☐
3.	I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.	☐
4.	I understand that I will not be identified or identifiable in any report subsequently produced by the researcher	☐
5.	I accept that taking part in an study intervention is voluntary and confirm that any risks associated with this have been explained to me	☐
6.	I agree to take part in the above study.	☐
7.	I agree to having the interview/focus group digitally recorded	☐

_____ _____ _____

Participant Name Date Signature

_____ _____ _____

Name of Person taking consent Date Signature

Qudratullah Nasrat

_____ _____ _____

Researcher Date Signature

The contact details of lead Researcher (Principal Investigator) are:

Proja e Taimani, Kabul Afghanistan

ANNEX 3. COMPARISON ANALYSIS OF HERAT AND SARIPUL

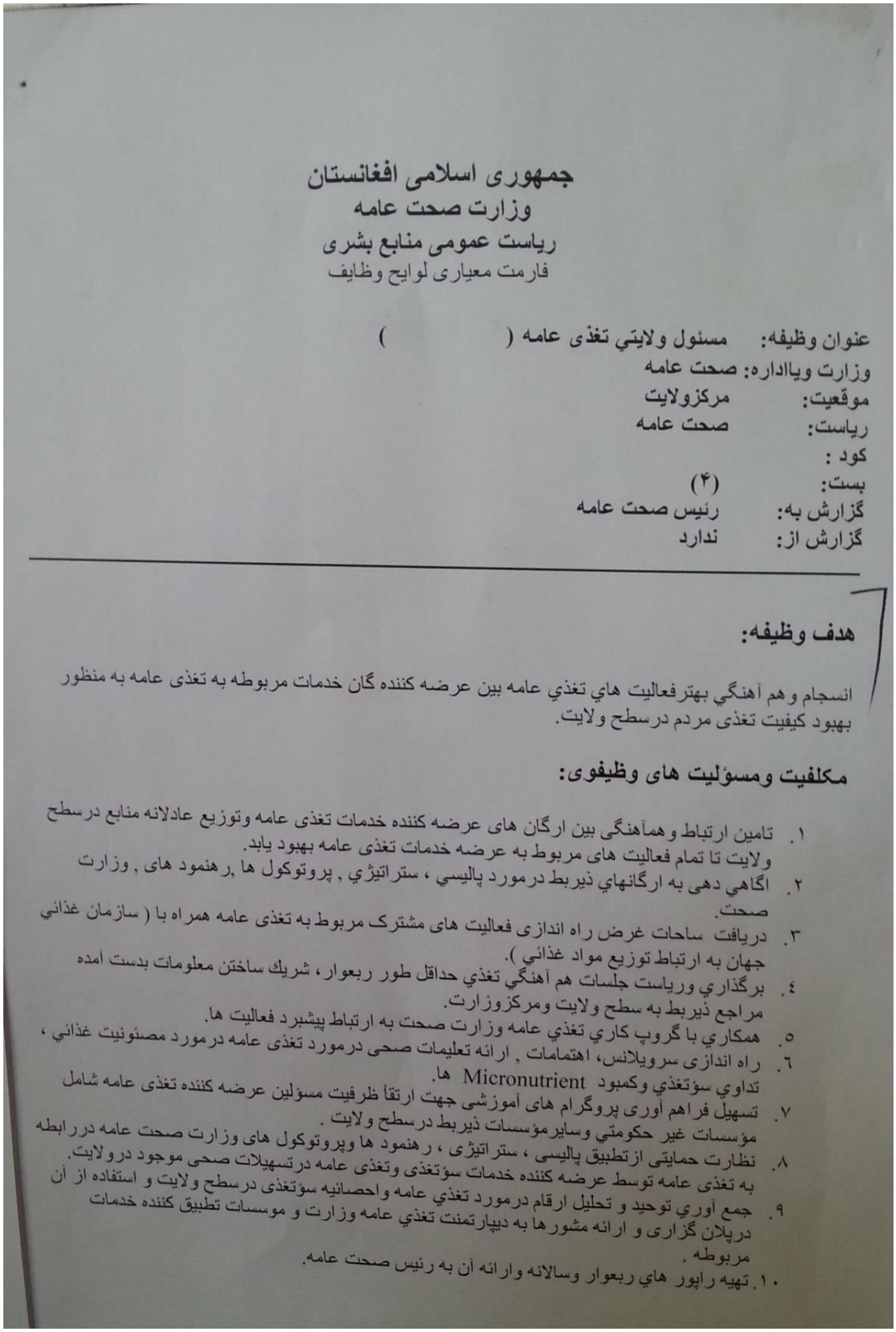
Comparison Analysis of Nutrition Service Delivery in Herat and Saripul

Category	SARPUL	HERAT BDN	HERAT DAC
Staff	uti	No staff for Nutrition services. The midwife or other staff provide nutrition services. "Based on BPHS organization our personal is complete. But we don't have particular staff as a nutrition in charge or nutrition nurse, we ask from midwives and nurses to identify malnourished children and refer them to paediatric hospital" CHC head. World Vision plan to support nutrition program in 5 health facilities where they plan to hire one nurse for nutrition program. The rest of 59 health facilities do not have a specific staff for nutrition.	DAC all facilities have nutrition nurse: Gozara hospital has two times more BPHS personal than other district hospitals based on MoPH Policy. We don't have any problem regarding personal and our hospital is supported by DAC. We have 4 personal for provision of nutritional services now.
	Initial trainings of 3 days and one week long conducted for all clinic staff for nutrition nurses this was repeated : there are equipment and nutrition supplies in every clinic	There is capacity at facility and management level for nutrition management; they evaluate and supervise our clinic, especially our nutrition section, but they don't have equipment and nutritional material to help malnourished mothers and children, we haven't received any nutritional material from them yet. BDN nutrition officer has been trained on 21 days TOT and he has delivered those to facility staff and HPs.	personal has received training in CMAM and IMAM: they are capable of providing nutrition services
IEC	There are materials for HE (poster, charts): there are one to two sessions on nutrition every week.	Health educations are only conducted by health facilities that received fund from World Vision and other organizations. Facilities provide HE but there are no education materials displayed at health facilities	
Funds/Budget (Management Support Services)	Budget is lump sum for all BPHS services; SCI provide materials for nutrition component.	Budget is lump sum for all BPHS services; No specific budget for nutrition services. They do however have plans for trainings of clinic staff as part of the general capacity building	
	Nutrition component is very well looked after. There is no specific transport for monitoring of nutrition but PNO feels supported to accomplish his monitoring of the facilities	Nutrition is not as good as EPI or TB: because of two reasons, first that these programs has separate and specific personal, and second that they have indicators.	
	Nutrition component is very well looked after. There is no specific transport for monitoring of nutrition but PNO feels supported to accomplish his monitoring of the facilities. PNO is very pro-active	currently there is no staffing and no materials considered. Staffing and materials should be included in order for the nutrition services to be at the level of EPI and TB. PNO is female and her movement is restricted to nearby health facilities	
		Facility staff are not well aware of the contents of the strategies for nutrition	

Comparison Analysis of Nutrition Service Delivery in Herat and Saripul

Category	SARPUL	HERAT BDN	HERAT DAC
Coordination	At provincial level there is coordination meeting every quarter to which stakeholders from MoAIL and NGOs come	Facilities do not know about coordination: but management say there are coordination meetings with stakeholders at PHO. In addition UNICEF convenes quarterly meetings on nutrition clusters. These help to avoid duplication	
	SCI: provides nutrition supplies, perform M&E of nutrition component:	World Vision: plans to support some 5 facilities to implement nutrition program; UNICEF supports a CMAM program in Chesh Sharif: and WFP support SFP in 5 districts	
Supervision	Yes: there is a PNO at province level. there is a nutrition nurse at DH and CHC level.	There is a technical manager who also oversees nutrition component.	
	PNO has TOR: PNO is trained on TOT, replicated the training, performs monitoring of BPHS health facilities in the most remote areas :	PNO has TOR: but newly hired and not trained on Nutrition	
	BPHS implementing partner is happy with the PNO; that he is contributing fully to the improvement of nutrition component. By training staff, performing monitoring: he visits nearby clinics once a month and visits the remote facilities once a quarter		
Training:	all facility staff have been trained on nutrition topics at least once. Nutrition staff have been trained more than one time on nutrition topics.		
	PNO and another doctor were trained on TOT but the second doctor has changed his job and departed to another province	PNO has not been trained due to the position being vacant at the time of the training. However the BDN nutrition focal point was trained and who also replicated the training to other staff of his facilities. Selection of staff for training was good and relevant people were introduced to the training	
	as per PNO all facility staff have been trained in Saripul	as per BDN nutrition focal point about 270 staff from different health facilities have been trained as well as about 600 CHWs.	
Service Delivery	No problem; security is a problem in many places. Some people complain that when they bring children they do not get food for their children, but this was explained by the clinic staff they give food to only those children who qualify for getting food.	lack of supplies and nutrition supplies is a problem. Security is a problem for accessing health services.	
	Mothers have no restrictions from family members in visiting health facilities	Mothers have no restrictions from family members in visiting health facilities: there is lack of staff and lack of materials	

ANNEX 4. PNO'S TERMS OF REFERENCE



جمهوری اسلامی افغانستان
وزارت صحت عامه
ریاست عمومی منابع بشری
فارمت معیاری لوایح وظایف

عنوان وظیفه: مسئول ولایتي تغذی عامه ( )
وزارت ویااداره: صحت عامه
موقعیت: مرکزولایت
ریاست: صحت عامه
کود :
بست: (۴)
گزارش به: رئیس صحت عامه
گزارش از: ندارد

هدف وظیفه:

انسجام وهم آهنگي بهترفعالیت هاي تغذي عامه بین عرضه کننده گان خدمات مربوطه به تغذی عامه به منظور بهبود کیفیت تغذی مردم درسطح ولایت.

مکلفیت ومسؤلیت های وظیفوی:

۱. تامین ارتباط وهماهنگی بین ارگان های عرضه کننده خدمات تغذی عامه وتوزیع عادلانه منابع درسطح ولایت تا تمام فعالیت های مربوط به عرضه خدمات تغذی عامه بهبود یابد.
۲. اگاهي دهی به ارگانهاي ذیربط درمورد پالیسي ، ستراتیژي , پروتوکول ها ,رهنمود های , وزارت صحت.
۳. دریافت ساحات غرض راه اندازی فعالیت های مشترک مربوط به تغذی عامه همراه با (سازمان غذائي جهان به ارتباط توزیع مواد غذائي).
٤. برگذاري وریاست جلسات هم آهنگي تغذي حداقل طور ربعوار، شریك ساختن معلومات بدست آمده مراجع ذیربط به سطح ولایت ومرکزوزارت.
٥. همکاري با گروپ کاري تغذي عامه وزارت صحت به ارتباط پیشبرد فعالیت ها.
٦. راه اندازی سرویلانس، اهتمامات , ارائه تعلیمات صحی درمورد تغذی عامه درمورد مصئونیت غذائي ، تداوي سؤتغذي وکمبود Micronutrient ها.
۷. تسهیل فراهم آوری پروگرام های آموزشی جهت ارتقاً ظرفیت مسؤلین عرضه کننده تغذی عامه شامل مؤسسات غیر حکومتي وسایرمؤسسات ذیربط درسطح ولایت .
۸. نظارت حمایتی ازتطبیق پالیسی ، ستراتیژی ، رهنمود ها وپروتوکول های وزارت صحت عامه دررابطه به تغذی عامه توسط عرضه کننده خدمات سؤتغذی وتغذی عامه درتسهیلات صحی موجود درولایت.
۹. جمع آوري توحید و تحلیل ارقام درمورد تغذي عامه واحصائیه سؤتغذی درسطح ولایت و استفاده از آن درپلان گزاری و ارائه مشورها به دیپارتمنت تغذي عامه وزارت و موسسات تطبیق کننده خدمات مربوطه .
۱۰. تهیه راپور هاي ربعوار وسالانه وارائه آن به رئیس صحت عامه.

۱۱. ماهانه یك هفته را غرض بازدید از تسهیلات صحی درساحه سپری نموده وگذارش ازبازدید خویش به اسرع وقت به رئیس صحت عامه ولایت ارائه نماید .
۱۲. تهیه راپور فعالیت های ربع وار وسالانه وارائه آن به رئیس صحت عامه
۱۳. انجام سایر وظایف مرتبط مرتبط به وظیفه که ازطرف رئیس صحت عامه سپرده شود.

مواصفات :

- نرس ، معاون داکتر وبه داکتر طب ارجحیت داده میشود.
- داشتن حد اقل یکسال تجربه کاري دربخش مراقبت های صحی اولیه.
- تسلط کامل به لسان های ملی
- داشتن مهارت درپروگرام های MS Office درکمپیوتر.
- داشتن توانائي سفر به تمام ولسوالي هاي ولایت وشرکت درسیمینار ها و ورکشاپ ها درمرکز.

ANNEX 5. JOB DESCRIPTION OF NGO NUTRITION SUPERVISOR

JOB DESCRIPTION

Title: **Communicable Diseases Control (CDC)/ Nutrition Supervisor**

Duty Station: xxx

Reporting to: Project Manager

Immediate subordinates: Staff of the clinics

Scope of Work

The CDC/Nut supervisor is responsible for implementation of the curative and preventive activities of the communicable diseases esp. TB, Malaria and HIV/AIDS as well as Nutrition. He/she accomplishes control activities of epidemics and health emergencies in concern province. He/she carries out his activities in consultation with health services and capacity building senior officer.

Entry Requirements

Formal Qualifications:

- Have Medical Degree from a recognized university

Experience:

- At least 3 years experience in Control of communicable diseases
- Being oriented with BPHS and EPHS program
- Previous experience in Laghman will be an advantage

Others:

- Good communication skills (written and spoken) of Pashto, Dari & English
- Ability to work effectively as part of a team
- Demonstrated skills in health management
- Strong interpersonal and communication skills
- Good supervisory, leadership, analytical and trouble shooting skills
- Ability to support colleagues and provide/receive constructive feedback
- Computer skills at operator level, especially with Ms. Office package
- Be an Afghan national

Responsibilities

General

- Act according to the policy and regulations of XX and health directives
- Keep updated with issues related to XXX and the environment where XX operates
- Promote an attitude of team spirit and a strong focus on quality
- Develop good co-operation with XX units, authorities, institutions and other NGOs
- Do related job as delegated by the Deputy BPHS and BPHS Manager

Supervisory Tasks

- Supervise the implementation of the national treatment protocols of TB, Malaria, HIV/AIDS and Nutrition at facility level
- Supervise epidemics control and health emergency activities in case happen.

- Supervision of at least 8 HF per months.

Technical Tasks

CDC

- To apply national treatment guidelines and policies of communicable diseases esp. TB, HIV/AIDS and Malaria at health facilities
- To ensure the existence of sufficient drug supply of communicable diseases (esp. TB, Malaria and HIV/AIDS) according to national treatment protocols
- To plan and implement vector control activities in the province
- To provide support and share HIV/AIDS related data and information to provincial HIV/AIDS staff (Health Services and Capacity Building Senior Officer/DPM)
- To ensure the existence of IEC material for awareness of community
- To ensure the existence of national guidelines at health facility level
- Regular follow up of WFP supplementary food for TB patients
- Keeping of WFP supplementary food distribution of all HFs
- Preparing WFP supplementary food distribution sheets for all HFs
- Planning, arranging and managing the promotive, supportive and representative activities such as (TB day, TB food distribution, TB drug supply, HIV/AIDS day and control of out breaks
- To plan monthly, quarterly and yearly plan of action for the visit of the clinics in the designated area of responsibilities of the supervisor
- Preparing monthly, quarterly and annual reports of the mentioned components and submitting to Health Services and Capacity Building Senior Officer/DPM
- Keeping soft copy and hard copy of monthly and quarterly reports

Nutrition

- To apply national treatment guideline and policies of nutrition at health facility level
- To ensure the existence of growth monitoring tools and sufficient drug supply of malnutrition according to national treatment protocols
- Ensured activities aimed at public nutrition, including assessment of nutrition status in the province
- Ensured preventive activities of malnutrition are based on the BPHS and MOPH guidelines
- Endured screening and monitoring of U-5 children at health facility level
- To ensure the existence of IEC material for awareness of community

Emergency preparedness

- To participate in the response teams to outbreaks and epidemics in the province
- To be able to do rapid assessment in case of emergencies or outbreak of diseases and coordinate with other health providers and report it to the project office for further help

Finance tasks

None

Training tasks

- Conduct TB, Malaria, HIV/AIDS and Nutrition trainings for the facility level staffs in his/her province
- Provide on the job training to health facilities staff on TB,HIV/AIDS, Malaria and Nutrition
- Training need assessment of the health facilities staff in relation to TB,HIV/AIDS, Malaria and Nutrition
- Introduce the health facility staff for the TB, HIV/AIDS, Malaria and Nutrition basic and refresher trainings

Tasks of intra-organisational relations

- Promote gender equality, non-discrimination with regard to ethnic, political and religious background
- To participate in workshops, seminars & conference organised by the XXX management
- Promotes good coordination with other XXX projects, all PO units

Tasks in relation with external agencies

- Maintain good cooperative relation with the national and provincial authorities, PHOs, NTP, CDCs, WHO,UN agencies, WFP, NGOs and other stakeholders
- To participate actively in ensuring broad understanding and acceptance by local communities of the Laghman BPHS project and XXX in general

Miscellaneous Tasks

- To actively contribute to the successful development and good reputation of XXX
- To do any other tasks within the field of competency as the Health Service SO and Project Manager/Deputy Project Manager assign

Authority
Personnel:

To give recommendations to the Project Health Manager on identification of needed staff, the recruitment, dismissal, disciplinary actions, and promotion of staff in the health facilities

Finance:

According to financial rules and regulations

Procurement & Purchase:

None

I have read, understood and agreed to the above job description. I have also received my personal copy of this job description on the below mentioned date.

Date:

_____

Signature of Employee

Endorsed by the Head of Health Program:_____

ANNEX 6. QUOTES FROM PARTICIPANTS

Staffing, Training and Capacity Development

Staffing

P7: If we look at Reproductive Health (RH) unit it has its midwife in the clinic, if we look at vaccination unit it has its vaccinator, and the same if we look at medicine unit it has pharmacists, but there is no responsible person for nutrition.

P13:... the load of work is so much on the current staff

P6: ….I don't know what they are teaching about nutrition in only 3 days?

P11: Our hospital has two times more staff than BPHS guideline prescribes for district hospitals based on MoPH Policy. We don't have any problem regarding personal for nutrition and our hospital is supported by funding other than GCMU

Training and Capacity Building

P13: they used to calculate malnutrition based on percentiles of normal nutrition but after the training they now use Standard Deviation and Z-Score which is new and better method for defining different types of malnutrition.

P11: Our participation was based on specific criteria, for example, being implementer of BPHS we maintain full commitment and work in nutrition section. The selection was completely accurate and then we were expected to transfer the knowledge to others.

P6: We agreed that we will conduct this training, we already conducted two trainings at hospital level; in both trainings all four of us (master trainers) took part, but after that we didn't have sufficient budget to arrange more such trainings.

P12: … Our organization's responsible staffs have commitment to their jobs and their work capacity is also good, and they evaluate and supervise our clinic, especially our nutrition section, but they don't have equipment and nutritional material to help malnourished mothers and children, we haven't received any nutritional material from them yet.

P24: Those health workers, who have received training, have good capacity but we all know that one of the major problems is that whenever a person is qualified then he quits and finds job elsewhere and it is one of the impediments in the way of improving nutrition services

P3: The health workers, who received training, have good capacity but we all know that one of the major problems is that whenever a person is qualified then he quits the health facility and finds job in another […]. It is one of the impediments in the way of improving nutrition services.

Management and Support Services

Role of Provincial Nutrition Officer & Nutrition Focal Points of NGOs

P6: In our job description it's mentioned that we should be in sites for one week in a month, we have 5 TPOs in provincial level and 6 salt factories, we also monitor 7 clinics so if we supervise all these place we will have very less time for office work as we have only 22 official days in a month.

P1: All provinces should have sufficient staff for nutrition departments. There should be organized and joint monitoring process and coordination among NGOs.

P11: …. this centre has been monitored twice in duration of 4 to 6 months; this should be increased.

P14: … but there is no budget, so he is not an implementer he is only a coordinator of meetings, they even have challenges in transportation so cant supervise regularly.

P21: …. someone cannot do anything with empty hand

*as per Table 5 on page 21, P14 refers to a PNO in Parwan province. To know about P11 and P21 please refer to table 5.

P3: For PNO there is only one big problem to provide him enough resources at least proper transportation to supervise all the health related programmes properly.

P11: Public Nutrition Department of MoPH should …seek the report of PNO activity and give feedback accordingly.

P14: A PNO must be supported logistically. More efforts must be put on their capacity building and the criteria for their recruitment of a PNO must be clear.

Role of Provincial Public Health Director

P1: Our PPHD does not pay any attention to nutrition. When we put forward a proposal for improving nutrition service delivery, he mostly ignores it. He is mostly focused on EPI because it has a lot of financial support

Coordination mechanism for nutrition service delivery

P6: Sometimes, NGOs are coming to this province and implement their activities without coordinating them with the BPHS implementing agency, Provincial Nutrition Office or Public Health Office

Budget for Nutrition service delivery

I: Can you tell us whether funds have been allocated for which components of nutrition?

P24: Whatever is included in BPHS, including prevention, treatment and screening etc. there is enough budget allocated for them by NGOs as part of the ongoing contracts.

P24: If you want to learn about over-spent or underspent [you will see] NGOs are not overspent in recently implemented projects. The NGOs get vertical projects from [other donors] because of which the real project is side-lined sometimes leading to duplication

P5: Our big problem is financial problem whenever we raise a problem to nutrition supervisor or nutrition responsible he is telling us that we don't have enough budgets for that.

Specific arrangements at local, provincial and national level

P2: There should be mobile nutrition teams and they should visit each and every home, convey information about nutrition, inspect children for malnutrition signs and tell parents on how to treat their children suffering from malnutrition.

P12: … we are being evaluated, but mere evaluation cannot solve the problems

Service Delivery

Delivery of sub components of nutrition through HFs

P6: Once I visited a clinic where I saw they put the scale in front of the gate and guard was checking, who was not even able to know whose weight should be checked and whose height should be checked, so if they are providing such services what resulted can be expected?

Supplies and commodities

P5: Another problem which we are facing is delaying the supply of materials by UNICEF and WHO. All the medicines which are provided by implementing NGO we don't have any problem with NGO but those materials for which UNICEF & WHO are responsible are not supplied on time

Nutrition Programme vs. other Programmes i.e. EPI, T.B.

P1: EPI was focused for the past even before BPHS and there is more commitment for EPI, but such commitment does not exist for nutrition

P24: EPI has gained attention for the last 50 years or before the development of BPHS. And nutrition is comparatively new thing. Secondly, there is greater commitment towards EPI.

P2: There are more seminars and training related to EPI but not for nutrition

Information, Education & Communication about nutrition

P 6: there should be advertisement through radio & television; there should be announcement through masjids and Ministry of Education for which we need trainings to inform all the people

P5: ... our staff is experienced and has received all the trainings on health education

P6… they talk about breast feeding and exclusive breast feeding Iodine and vitamin A…

P21: …. That… after six months of life beside breast milk they can feed their babies with complementary food six times per day

P11: We perform food demonstration in which our nurses prepare nutritious food in presence of mothers and explain the process to them and then give that food to their children

Barriers to nutrition service delivery

FGD3: when we come to health facility, we are treated like animals by some health facility staff especially male staff

FGD 5: the health facility is very far from our homes and when we go there we have to wait for long time. And after waiting for long time, we receive nothing

FGD 6: The health facility has no proper space for women. Men and women are mixed. Our husbands do not allow going to such areas.

P2: One of the problems is that about 80 per cent of women are not allowed by their husbands and in-laws to visit clinics. When we advise them to visit the clinic after one month they say their in-laws don't allow them. One of the patients told me that she managed to get permission after begging for a month and that she couldn't come again.

P8… you are aware of the fact the some mothers are not allowed by their families to visit hospitals

P2: we have no material other than equipment to check their weight and height etc. to check whether the child is suffering from malnutrition or not which is frustrating.

P4: …. a big problem that we always need to refer all cases to other facility but families can't go..

Quality of Services

P7: The quality assurance standards we are using, nutrition is not available at all if can include it as well it will be better.

P8: nutrition programme is one of seven elements of BPHS, so adequate budget and staffs should be allocated to this section too, in this case the staffs will be capable of giving appropriate education and care to malnourished children.

Exposure to Interventions

Complementary projects to BPHS

P16: When a project is handed over to NGO it implements the project in coordination with us. Provincial Public Health Office doesn't manage it independently; we just evaluate, monitor and give our feedback. It would be better if all these activities are performed directly by MoPH.

P1: If vertical projects are suspended then it could create a little gap but later on I believe it will improve.

I: What is your opinion about need for nutrition staff at health facilities?

P24: Nutrition is a basic component and working priority of BPHS but donor's interest is very less.

P24: The present staff can cover [the assigned tasks in HFs] in most of the health facilities but the main thing is donors' interest and provision of necessary material

Pilot projects

P3: I also suggest to MoPH to have proper coordination and control all the pilot projects and assess whether the pilot projects are according to the need of people in this or not?

Policy, Planning, Monitoring and Evaluation

Awareness about policies

P12: I haven't studied MoPH Policies and strategies with regards to nutrition so I am unable to comment on it.

P13: We did not receive the strategies and policies, which are developed by the MoPH to be implemented in field level

P5: …there is no gap in policy; the major problem is in implementing the policies

Revision of the policies

P11: current policies should be reassessed. First more personal should be recruited, other it is in policy to include women who are pregnant for 4 months in nutrition program, which is clinically difficult for us to identify such women. Previously we were including women who were 6 months pregnant and for 3 months after delivery, in nutrition program.

P1: .. unavailability of material is a gap itself… folic acid tablets were not properly distributed among anaemic women and even its composition was not standard

P4: Considering incentives for Community Health Workers (CHWs) will be more helpful to identify more Nutrition cases

Planning, Monitoring & Supervision from nutrition service delivery

P6: When MoPH receives a proposal from an NGO that should be revised by nutrition department so that all nutrition related problems could be highlighted.

One of the participants (P22) mentioned that donors might conduct studies aimed at identifying challenges and problems. In the view of these studies, donations should be provided accordingly.

P22: Evaluation and surveys should be conducted in every aspect of nutrition that problems could be explored in nutrition section and then accordingly solutions could be sought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