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Thesis Title: Child Mortality: Fathers' Perception of Child Health in Bibi Mahrov Area of Kabul, Afghanistan
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Child Mortality: Fathers’ Perception of Child Health in Bibi Mahru Area of Kabul, Afghanistan

by

Said Salem

A thesis submitted in partial fulfillment of the requirement for the degree of Master in Development Studies

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August, 2011
Declaration

Statement by Author

I, Said Salem, declare that this Supervised Research Paper is my own work and that, to the best of my knowledge, it contains no material previously published, or substantially overlapping with material submitted for the award of any other degree at any institution, except where due acknowledgment is made in the text.

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Acknowledgements

I am heartily thankful to my supervisor Professor Virginia Tilley, for her assistance, guidance and support from the beginning to the end and enabling me to understand the subject. Her expertise and professional guidance are highly appreciated.

Also I would like to thank my second supervisor, Dr Lynda Newland, for her professional advice and her interest in this thesis.

This thesis would not have been possible without the professional and moral support of my dearest wife Matilda. Also, I would love to thank each of my children, Samina, Sial, Sana and toore sterge Sahil Baba, for their love and good behaviour.

I extend my thanks to family and friends in Kabul who helped me in my field work, especially to uncle Murzanoor, who gave his time, taking me to the field in his car and helping me to find people to interview. Also, I would like to thank my sister Samia, who helped me to transcribe the interviews. Also I would like to thank my brother Nazem, who guided me and supported me with my field work.

I would like to thank Save the Children staff in Afghanistan who gave their precious time to meet with me and provide me with professional information about the child health situation in Afghanistan. Finally, I would like to thank the fathers that spent time with me telling me about their lives, their difficulties and their children, and for their hospitality.
Abstract

Despite significant research having been done on the role of mothers in child health, we know very little about the role of fathers in this area, particularly in Afghanistan, where child and infant mortality rates are amongst the highest in the world. The fathers' role in the family has been seen more as a breadwinner and resource provider.

This exploratory qualitative thesis is based on interviews with 13 fathers in Bibi Mahru area of Kabul city, a focus group discussion, and observation of the area. It found that fathers have a direct role in supporting family and child health. These fathers love their children and were emotionally sad about the loss of children to disease. Fathers in Bibi Mahru perceived that unsafe water and sanitation are the main threats to their children's health in the area. However, some of the fathers also believed that the dirty environment, poor food, poverty and lack of access to proper health services were also major causes of sickness for their children. Although, most of the respondent fathers understood relevant threats to their children's health, most of them found it difficult to assess and respond to the seriousness of the threat. Most of the fathers did not know the causes of their children's deaths.

Fathers are an important part of the family, having a positive impact on child health outcomes, particularly in traditional Afghan society, where the movement of women is restricted and where men have more decision-making power. Therefore, more research needs to be done on the fathers' role in child health and health planners could benefit from including fathers in child health programmes.
# TABLE OF CONTENTS

**ACKNOWLEDGEMENT** ........................................................................................................... I

**ABSTRACT** ................................................................................................................................ II

1. **INTRODUCTION** ....................................................................................................................... 1

2. **CONTEXT OF AFGHANISTAN** .................................................................................................... 6
   2.1 **CONFLICT IN AFGHANISTAN** .............................................................................................. 7

3. **METHODOLOGY** ........................................................................................................................ 11
   3.1 **METHODOLOGY OVERVIEW** ............................................................................................... 11
   3.2 **INFORMANTS** .......................................................................................................................... 13
   3.3 **FOCUS GROUP INTERVIEW WITH FATHERS** ......................................................................... 14
   3.4 **OBSERVATION** .......................................................................................................................... 15
   3.5 **PHOTOGRAPHS** ....................................................................................................................... 15
   3.6 **PROBLEMS DURING FIELD WORK** ....................................................................................... 16

4. **THE STUDY AREA, BIBI MAHRU, KABUL** ........................................................................... 17
   4.1 **HEALTH RELATED CONDITIONS IN BIBI MAHRU** ............................................................... 18
   4.2 **FATHERS’ UNDERSTANDING OF CHILD HEALTH** ................................................................. 19
   4.3 **FATHERS’ UNDERSTANDING OF CHILD DISEASES** .............................................................. 19
   4.4 **FATHERS’ ROLES IN CHILD HEALTH** .................................................................................. 22
   4.5 **FATHERS’ PERCEPTION OF THEIR ROLE IN THE FAMILY** ..................................................... 24
   4.6 **FATHERS’ PERCEPTION OF MOTHERS’ HEALTH** ................................................................. 25
   4.7 **FATHERS’ PERCEPTION OF CLEANLINESS OF PHYSICAL ENVIRONMENT** .................................. 26
   4.8 **FATHERS’ CONCERN ABOUT THE HEALTH SYSTEM** ............................................................ 29
   4.10 **FATHERS’ CONCERN ABOUT THE HEALTH SYSTEM** .......................................................... 29
   4.11 **SUMMARY OF FINDINGS** ...................................................................................................... 30

5. **THE GLOBAL CONTEXT OF REDUCING CHILD MORTALITY** .............................................. 31

6. **CHILD MORTALITY IN AFGHANISTAN** .................................................................................. 33

7. **GENDER: WOMEN’S POSITION IN AFGHAN SOCIETY** ....................................................... 37

8. **WOMEN’S HEALTH** ................................................................................................................... 41

9. **WOMEN AND DEVELOPMENT AND DECISION-MAKING** .................................................... 43

10. **MOTHERS’ AND FATHERS’ EDUCATION AND CHILDREN’S HEALTH** .................................. 47
    10.1 **MOTHERS** .................................................................................................................................. 47
    10.2 **FATHERS** .................................................................................................................................. 48

11. **CONCLUSION** .......................................................................................................................... 52

12. **REFERENCES** ........................................................................................................................... 54

13. **Annex 1: PHOTOGRAPHS** ...................................................................................................... 68
1. Introduction

*My children are the most precious human beings for me. Whatever it takes for me, I will provide them with food.*” A shop keeper in Bibi Mahru settlement, Kabul.

*When I come home from work in the evening, I look at my children and all my tiredness goes away.*” A tailor, resident of Bibi Mahru settlement.

In Afghanistan, development actors have not adequately taken into account the role of Afghan fathers in the family. This may be due to bias resulting from gender stereotyping that sees fathers as only breadwinners and minimally involved in the day-to-day affairs of children. Fathers are breadwinners, but they are often also carers for children and decision-makers, who usually try to do their best to keep their children healthy. As will be seen below, this research shows that there are fathers who are trying to feed their children adequately, to provide conditions in which they can be healthy and ensure that their children receive good health care. However, in the difficult context of Afghanistan, where one out of five children dies before reaching the age of five, there are fathers who are struggling and feel that they are not receiving the support that they need to protect their children’s health.

Research and child mortality reduction programmes have focused on the mother’s relationship to child health. It is clear that mothers have a direct impact on child health and the reasoning behind the focus on mothers therefore has logic. However, it appears that this approach has not been sufficient, at least not for Afghanistan.

More than thirty years ago, a prominent child psychologist Michael E. Lamb (cited in US Department of Health and Human Services, 2004, p. 1) said that fathers are the “forgotten contributors to child development.” A recent study of urban, low-income
fathers in the US has indicated that fathers are significantly involved in child health. It found that health providers have a bias in assuming that low income fathers are not involved in their children’s health, whereas in fact these fathers were (Preidt, 2011). According to Hewlett in 1991 (as cited in Jahn & Aslam, 1995, p. 192) in non-Western societies “researchers do not know much about the fathers’ role and simply claim that it is minimal. These factors have contributed to the complete absence of systematic studies in non-Western societies of the fathers’ role in infant and child development.” Although there has since been research carried out on the role of fathers in child health and development, in both developed and developing countries, including in Bangladesh, Malaysia, Turkey and Indonesia (see below), the emphasis remains on maternal influences and Hewlett’s finding remains highly relevant for Afghanistan.

In Pakistan, research found that fathers were not only the income provider for the family, but they were also carers for children’s health and key decision-makers on child health issues. The study concluded that approaching child health only through mothers “lags far behind social reality” (Jahn & Aslam, 1995, p. 204).

Studies have found that fathers’ contribution and their involvement in child development have a positive impact on child health, well-being and better development outcomes for the society as a whole, and argue that fathers must be educated and included in health programmes since they are important in influencing their children’s health (Preidt, 2011). 1 On the basis of a study in black neighbourhoods in the US in 1979, Pedersen, Rubinstein and Yarrow (cited in Allen, & Daly, 2007) found that when fathers were involved in a high level of play and care giving activities, infants were more cognitively developed and competent at 6 month of age and scored higher on the Bayley Scales of Infant Development, and in year one these toddlers were better at problem solving. Another study in the US also found school-age children who had an involved father in their life scored much better

1 In many studies regarding Bangladesh’s child health, it has been found that father’s involvement in child health has a positive impact on child health outcomes. A study by Semba et al, (2008, p. 325) found that a father’s education and income had a positive impact on children’s nutrition, and reduced stunting.
in school and they were better in quantitative and verbal skills, compared to children without involved fathers. Furthermore, children with involved fathers are more likely to overcome frustration, difficulties and stress (Mischel et al., 1988, p. 693).

Research has also shown that the involvement of fathers in their child’s development is not only beneficial to the child, but it also has a positive outcome for fathers themselves. Men who were engaged with their children felt confident and effective as parents and also behaved better in society (Almeida & Galambos, 1991, cited in Allen & Daly, 2007). Again, it will have a positive impact on child well-being to have a father who is himself mentally fit.

The role of fathers in family health in developing countries has also been recognised by the international development community. In 1994, the International Conference on Population and Development emphasised the need to increase the involvement of men in parenting and measures to improve maternal and child health. This was based on the recognition that men’s attitudes, knowledge and behaviour influence health in the family (International Conference on Population and Development, 1994). Further, the World Bank found that:

*Strategies to affect health behaviour need to influence the attitudes of all those involved in making health decisions. In Bangladesh, decisions regarding health and nutrition do not rest solely with the mother, but also the husband* (World Bank 2005a p. 31).

In Afghanistan, although literature exists on rates and physical causes of child mortality, not much literature has explored qualitative determinants of child mortality, nor has the literature explored cultural issues. More particularly, research has not addressed the roles of mothers or fathers in child health. However, in line with global trends, a literature review on child health and parents’ roles in Afghanistan will find research on “mothers’ education and their autonomy in decision-making” (Mashal, & Takano, 2008), but will not find any literature focused on the fathers’ role. Some literature has addressed the role of the community or family in general (Maarij, 2005), and Save the Children carried out a survey on
parents’ understanding of child development, which separated out the results for mothers and fathers.²

The lack of such qualitative research in Afghanistan is concerning. The country has one of the highest rates of child mortality in the world and a slow improvement rate (You, Jones, & Wardlaw, 2011, p.11). The lack of qualitative research on child mortality is despite the fact that globally, Afghanistan is one of the largest aid recipients (Lambel, 2011) and donors and the Government alike have committed to significant reductions in child mortality. It would therefore seem that programmes to reduce child mortality in the country are not working effectively.

This study was designed to begin to explore the gap in understanding how fathers themselves see their role in child health and prevention of child mortality, with the aim of deepening the understanding of the role of fathers in improving child health and to see whether more research is needed in this field.

Section 2 begins with some background information on Afghanistan to provide the reader with an overview of the context. Section 3 outlines the methodology. Section 4 has the findings from interviews with fathers and informants in one district of Kabul city, Bibi Mahr. This section covers the findings on conditions in which families live, and the role and attitudes of fathers regarding child health.

In order to situate the research in the context of child mortality issues more broadly, section 5 examines the scale of the problem and efforts towards reduction in child mortality rates world-wide. Section 6 examines in more detail child mortality in Afghanistan. Section 7 explores gender issues in Afghanistan with the aim of understanding the links between women’s status and the poor child mortality rates in the country, and how fathers’ involvement may impact on these issues. Section 8 examines how mothers’ and fathers’ health impacts on child health, since research in

²A survey by Save the Children 2009, found that in Afghanistan the majority of parents in rural areas “do not understand child development.” Only 19 per cent of mothers believed that playing with children is useful and will promote learning. Only 4 per cent believed that it will prepare children for school. None of the fathers in the survey understood that playing with children will help them to improve their cognitive development. (Save the Children in Afghanistan, 2009).
this area has supported the argument that fathers’ role in child health is important, particularly in country contexts similar to Afghanistan. Section 9 looks at women’s role in development and decision-making. Section 10 looks at the impact of mothers’ and fathers’ education on child health. Finally, Section 11 provides the reader with conclusions.
2. Context of Afghanistan

Afghanistan is located in southern Asia, bordered by China, Pakistan, Uzbekistan, Iran Turkmenistan and Tajikistan. It is a land-locked and mountainous country with plains in the south and north. It covers an area of 652,100 square kilometres. The capital city is Kabul.

Due to immigration and political instability, the exact figure of the population is unknown. However, it is estimated to be around 28 million people, growing at a rate of 3.9% annually. The total fertility per woman is 6.5 children. Forty-six per cent of the population is estimated to be fourteen years or younger (UNICEF, 2010).

Map 1: Afghanistan and its provinces (Central Intelligence Service, 2007).
Afghanistan is a multi-cultural Muslim country, with a majority following Sunni Islam and an ethnic minority following Shia Islam. The two largest ethnic groups are Pashtun and Tajik, whose languages are Pashtu and Dari respectively. These are the official languages of the country. There are, however, more than thirty languages spoken in the country. Other ethnic groups in Afghanistan include Uzbeks, Turkmen, Hazara and Balooch (Central Intelligence Crevice, 2007).

2.1 Conflict in Afghanistan

In order to understand any development issue in Afghanistan, it is necessary to understand the disastrous impact that conflict has had on the country and its people. In terms of understanding the role that fathers play within the family and how their decisions and behaviour are relevant to child health, it is also necessary to see the context in which families have been living.

The last thirty years of war in Afghanistan destroyed most of the government and community establishments and physical infrastructure of the country. The war weakened state institutions. Estimates of the death toll from the wars since the Soviet Invasion in 1979 to 2001 range from one to two million (White, 2011). Even more were internally displaced or forced to seek refuge in other countries (OXFAM, 2009, p. 3).

In a report examining conflict and its costs for Afghanistan, a man from Kunar described his own experience of war:

> Three decades of war created a lot of problems for us. We migrated to Pakistan, our houses were destroyed, our land and property were grabbed by warlords, the economy was badly affected, our sons and daughters were deprived of education, our women were insulted... schools, hospitals, roads and factories were destroyed and fear of war has caused many mental problems. (OXFAM, 2009, p. 5)

The 1979 invasion of the Soviet forces led to an ongoing war in Afghanistan. Although the Soviet forces withdrew from the country in 1989, they left a
government without a strong military force. By 1992, the mujahedeen\(^3\) took control of the country. The mujahedeen had fought against the Soviet invasion and were supported by the US, Arab countries and other foreign powers. They were led by commanders who often represented different ethnic and other groupings in Afghanistan. Each group had its own leader and once they took power, this led to infighting between the groups for control of the country (OXFAM 2009, p. 3).

In the early days of mujahedeen control, people had high hopes for a stable future. However, the different factions of the mujahedeen turned on each other and started a bloody fight to take control of the country. As a result many ordinary people became victims of random violence, robbery, rape, torture and body mutilation (Gill, 1993, p. 2 as cited in Dorronsoro 2007, p. 15). In 1996, the Taliban took control of much of the country and remained in power until 2001, when a US-backed invasion ousted the Taliban. After the fall of the Taliban, around five million refugees from Pakistan and Iran returned to the country and there was great hope that peace would finally be established in Afghanistan (UNHCR, 2011). However, the conflict has continued with US forces and then NATO International Security Assistance Forces fighting the Taliban and other groupings that oppose the government or the foreign forces. The conflict has focused mainly on the southern and eastern parts of the country (Walsh, 2006).

With three decades of war, a whole generation grew up in conflict. They never experienced peace. This has left Afghans in a vulnerable position, trying to cope with the economic, mental and social consequences of war. A report by OXFAM indicated that of 704 randomly chosen people from 14 provinces, approximately 43 per cent reported that their property was destroyed; around 25 per cent had had their agricultural land destroyed; and 76 per cent reported having been displaced at least once from their homes. Estimates indicate that millions of Afghans were displaced over the period of the conflict, many experiencing repeated displacements. During the Soviet invasion period alone, there were estimated to be five million refugees, mainly in Pakistan and Iran, and two million internally displaced persons (OXFAM, 2009).

\(^3\) In Islamic tradition, a mujahed is a fighter for Jihad. Jihad is holy fighting in the cause of Allah. Mujahedeen is the plural of mujahed.
These effects of war led to a deepening of poverty in Afghan society, trapping many people further into poverty. Almost 9 million people, 36 per cent of the population, live in absolute poverty. These people cannot meet their basic needs of life. Another 37 per cent lives slightly above the poverty line, which makes them vulnerable in the face of any difficult situation such as food security, natural disaster and the need for medical care (Office of the High Commissioner for Human Rights 2010a). In its 2007 Human Development Index (HDI) report, UNDP ranked Afghanistan as 174 out of 178 countries in the world, where 178 is the least developed country (UNDP, 2007). By 2011 HDI for Afghanistan showed a little progress; the country was ranked 172 out of 178. (UNDP, 2011 p. 2).

Historically and continuing into the present, Afghanistan has had a weak central government, which has limited the ability of the government to provide assistance and services to parts of the country beyond the capital and in particular to rural areas. The current government has done little to improve communication and transportation between rural and urban cities. This lack of support to rural areas has led to urban and rural disparities in community living standards (Office of the High Commissioner for Human Rights, 2010a). Poverty is estimated to be 18 per cent higher in rural areas (International Fund for Agriculture and Development, n.d.).

Research supporting the 2008 Afghan National Development Strategy (ANSDS), the country’s poverty reduction strategy, found a number of factors that contribute to poverty in Afghanistan, including a lack of infrastructure, continuing conflict, access to markets and social inequality (ANSDS, 2008). However, corruption is another key factor that also drives poverty in Afghanistan. Corruption limits access of a large proportion of the population to services such as security, food and shelter (Office of the High Commissioner for Human Rights (2010a).

The ANSDS recognises the need to support the return of refugees and resettlement of internally displaced persons in Afghanistan. The Strategy includes plans to help integrate these groups voluntarily into communities (ANSDS, 2008, p.13). The

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4 Absolute poverty has been defined as “a condition characterised by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also access to services” UN, 1995 (cited in Gordon, 2005: 3)

5 The HDI ranks countries in relation to human development indicators such as levels of education, health, poverty and access to resources (UNDP, 2007).
majority of returned refugees and internally displaced persons have resettled in the major cities, in particular Kabul.
3. Methodology

3.1 Methodology Overview

The researcher wanted to work on issues that related to the high child mortality rate in Afghanistan and had a particular interest in how fathers interrelated with this issue. From a practical perspective, he also was aware that in any research that he carried out in Afghanistan, he would only be able to interview men. In Afghanistan traditions decree that unrelated men and women are not allowed to speak to each other beyond simple business-related interactions. On the basis of these factors, he decided to design a research question that would address issues related to the way fathers perceive their role in child health and child mortality. The researcher considered whether to carry out research in a rural or urban area and decided to go to an urban area where there would be a less homogeneous group than in a village setting. In this regard, the Bibi Mahru area of Afghanistan was selected because it is an area where all the residents are poor and no divergence between different families’ living standards is apparent. On the basis of these factors, the researcher designed the following research question: what is fathers’ perception of their role in their children’s health in the Bibi Mahru area of Kabul?

After designing the question, the researcher located relevant secondary sources to help guide him in the design of his research, as well as to provide relevant background and context for his thesis. One research paper, Fathers’ perception of child health in a squatter settlement, Karachi, by Jahn and Aslam, stood out as being particularly relevant in relation to both the content of the research and the cultural context. The researcher therefore used aspects of Jahn and Aslam’s methodology to guide his own research (Jahn & Aslam, 1995), in particular in determining a number of the topics for discussion in the interviews with fathers. Although using aspects of Jahn & Aslam’s methodology, this paper produces original data and findings, based on the different country and period.

In order to answer the research question, the researcher decided to use direct interviews with fathers, focus group discussion and interviews with local people with

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6 The researcher was carrying out his research as a part of his study for a Master’s degree for the University of the South Pacific and was self-funded.
particular knowledge of the community. The interviews carried out for this research were exploratory and intended to produce some preliminary findings to indicate the need for further research. The researcher agreed with interviewees not to disclose identifying information, in order to protect confidentiality of the information given and to encourage frank discussions. On the basis of the materials collected, relevant literature was reviewed to help understand and contextualise these preliminary findings.

Interviews were carried out from 5 July to 4 August 2011. The interviews were based on a qualitative approach. The major objectives were to gain an initial understanding of fathers’ perception of their children’s health in the Bibi Mahru area of Kabul city. Rather than using an interview with coded responses, this research used open-ended questions to generate responses, as well as a focus group interview and observation of the physical environment and the behaviour of fathers and mothers with children in public places. The researcher used a checklist during the discussion to ensure that all key topics were included (see Annex 2). In designing topics for interview, the researcher based aspects of the checklist on results found in the research carried out by Jahn & Aslam (1995). In particular, the researcher included issues regarding fathers’ forms of participation in the household and in child care, fathers’ understanding of threats to family health, the autonomy of wives and decision-making about child health issues, the physical environment, food and nutrition and poverty-related issues. The structure of this explorative paper similarly includes these issues.

Respondents were selected by directly approaching people in the street and in shops in Bibi Mahru and asking whether they would have time for an interview. This initial approach has some likeness to purposive sampling in that potential subjects were selected according to some criterion, but this was a very blunt criterion in the present study. The actual sampling was really closer to snowballing because of the expansion of the subject base through the information and guidance of the subjects. Thus the researcher used the snowballing method as he asked family, friends and the interviewers in Kabul to help identify people in Bibi Mahru for interviews.

Observation was also carried out with the objectives of understanding what kind of environment and hygiene practices existed in the area; the role fathers play in
childcare in the public sphere (for example to see whether fathers were taking their children out, and whether fathers or mothers were carrying children); and what kind of food was available in the local shops of Bibi Mahru.

3.2 Informants

Information was obtained from initial scoping interviews with 13 fathers, the head master of the Bibi Mahru School and a Mullah of one of the Mosques. The aim was to include different target groups in the area with respect to age, socio-economic status and occupation. Only men with children were interviewed. Names and identifying features of informants have not been included in order to ensure confidentiality. It was agreed with informants that any information given would not disclose their identities.

| Table 1: Distribution of Schooling among Respondents |
|---------------------------------|----------------|----------------|----------------|
| Education                      | Illiterate   | 1-12 years schooling | Higher Education |
| Number of Respondents          | 6            | 5               | 2              |

Of the 13 fathers, all but one was employed. Employment included being a shop keeper, a construction worker, taxi driver and tailor. The age range was estimated to be from late 20s to 50s. All the fathers were either earning income or, in the case of the one unemployed father, were in a household which had a regular income. However, all informants felt that they were only just managing to meet their basic needs with the income earned. Family sizes ranged from three to nine surviving

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7 In Afghanistan, most adults do not know their age and have no official record of their date of birth. Therefore, age was only estimated through observation.
children. Six of the fathers were illiterate, two had primary level schooling, three had secondary schooling and two had higher education.

I interviewed the Mullah in the Bibi Mahru Mosque to find out about his perception of fathers’ role in child health. He was an important informant, since in Afghan society, religious leaders such as mullahs have a huge influence on men. The mosque in Afghan society is not only used as a place of prayer, but people also go to the mosques to learn. Mullahs have significant authority and their speeches in the mosque are widely listened to during prayer and other male community gatherings.

For a further understanding of child health issues, a doctor was also interviewed, who worked for Save the Children, a large non-governmental organisation that has worked in Afghanistan for many years. In Afghanistan, Save the Children works to improve the lives of children through both development and emergency programmes.

On several occasions, attempts were made to interview staff in the Bibi Mahru local health clinic. Unfortunately, the staff of the clinic could not provide any information about their activities in the area, finally saying that “we are not allowed to talk to anyone about our activities without the permission of the Ministry of Health.”

Notes were taken during the interviews and written up immediately after the interviews. Interviews were conducted both in Pashtu and Dari.

3.3 Focus group interview with fathers

Due to the limited time for research in Afghanistan and the limited availability of fathers due to their long working hours, one focus group interview was held on a Friday, the weekly day off in Afghanistan, with seven fathers in the Bibi Mahru area. Men with children who were residents of Bibi Mahru area and had no close relationship to the other participants in the focus group were chosen.

Contact with the participants of the focus group was made through some of the fathers that had already been interviewed and also through pre-existing contacts of

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8 Others have also recognised the importance of Mullahs in affecting social attitudes and community knowledge in Afghanistan. For example, family planning programmes, such as a USAID project run by Management Science for Health, have enlisted Mullahs to promote family planning messages to men in communities. (Management Science for Health, 2007, p. 3).
the researcher in Kabul. The focus group interview was held in the local mosque on 29 July 2011, after the lunch-time prayer, at approximately 2 p.m. Four of the focus group participants were illiterate fathers, one had education up to year 10 and two of the fathers had completed school up to grade 12. Five of them had between one and five children that had died. Three of the fathers were working as day labourers; one was a shop keeper; one a butcher; one a taxi driver; and one was retired.

The focus group was mainly conducted in Dari, but at times, some people also spoke in Pashtu. The discussion focused on fathers’ perception of child health, but it also covered the physical environment of Bibi Mahru. The focus group was facilitated by the researcher alone, since he did not have any accompanying researchers with him to assist.

3.4 Observation

Informal observation of the area was conducted to observe both family behaviours and the physical environment in Bibi Mahru. In particular, the researcher was looking to identify father and child interaction, including the role fathers play in childcare in the public sphere, and the physical environment of the streets and houses, with a particular focus on hygiene. In addition, observation of food availability in local shops was included. The observation sites were streets, residential houses, the local school, a bus stop, a local clinic and shops.

3.5 Photographs

In order to observe more fully and to show readers the physical environment and lifestyle in the Bibi Mahru area, photographs were taken of places such as streets, households and shops in the area (see Annex 1).

However, the men interviewed did not want to have their photographs taken. They considered discussions about their family private and so they did not want to be identified in any way.

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9 One key contact was a friend of the researcher since childhood who, now lives in Bibi Mahru. In addition, close relatives of the researcher spoke with workmates and found other contacts that live in Bibi Mahru.
3.6 Problems during field work

For the most part, fathers were working very long hours, and in some cases had more than one job, and therefore it was difficult to find fathers who were available and willing to participate in an interview. The time taken to identify fathers willing and able to give interviews, combined with the time limitation for research in Afghanistan was one of the major problems during the field work.

It was difficult to ask questions regarding the fathers’ wives, since cultural restrictions do not allow an unrelated man to ask about a man’s wife. Also, since the only researcher was a male, he had no opportunity to interview the wives. This made it difficult to gather information on the father’s role in mother’s health and other related issues. In addition, the interviewees refused to allow the taking of photographs and tape recording of interviews.
4. The Study Area, Bibi Mahru, Kabul

Situated in the north-west of Kabul, Bibi Mahru is an overcrowded settlement in one of the poorer areas of the city. Due to the frequent relocation of residents, the exact number of the population is not known. However, according to the head of the Bibi Mahru School, the area has an estimated 30,000 people. He estimated that approximately two to three extended families live in each house. According to the fathers interviewed, during the years of conflict the majority of people have been internally displaced from different parts of Afghanistan or are returned refugees from Pakistan and Iran. Internally displaced people and returning refugees have settled all over Kabul. However, the high concentration of these groups in Bibi Mahru is due to the availability of cheap residential housing. Residents are employed in positions such as public servants, army officers, self-employed, teachers, tailors, non-governmental organisation (NGO) workers, retirees and many unskilled casual workers.
From observation, it appeared that the majority of residents were Pashtun and Tajik. However, throughout Kabul, there are also other ethnic minorities, such as Hazara, Uzbek and Turkmen and it would be expected that these ethnic groups are also present in parts of Bibi Mahru. Although there are no statistically differences of fathers understanding of children’s health among different ethnic group, however, for this thesis researcher was only able to interview Pashtun and Tajik. Fathers interviewed for this research were Pashtun and Tajik only.

Use of alcohol is prohibited in Afghanistan and therefore in Bibi Mahru settlement as well. However, some people smoke (charse) marijuana and opium, which are very cheap and can be obtained easily.

4.1 Health related conditions in Bibi Mahru

Unsafe water and poor sanitation constitute a major health issue in Afghanistan, particularly in Kabul. According to the Ministry of Urban Development, 70 per cent of the population of Kabul has no access to clean water (Tolo, 2011).

Observations of the Bibi Mahru settlement found that there are two types of wells: private hand-pump wells that are on people’s private land to supply their houses, and public hand-pump wells that were built by NGOs on the side of the streets. Most of the toilets in the settlement are one of two types of traditional latrines that are not connected to a proper sewage system. The toilet waste from both types empties into small dirt canals on the side of the street or just into dirty puddles. The canals are not connected to a larger system and the waste is left in the streets. There is no playground for children in Bibi Mahru area to play.

According to residents interviewed, most household rubbish was not collected by the local municipal council. This was also confirmed through observation. Electricity is available in almost every house; however, the supply of electricity is sometimes interrupted, particularly when the demand is high, especially in winter.

For general health issues, households have access to local government clinics. These clinics focus on provision of mother and child health services, such as immunisations, antenatal care and basic health education. Families were not visited
by community health workers. For more serious health problems, people go to private clinics, doctors and government hospitals.

4.2 Fathers’ understanding of child health

It is important in looking at fathers’ perception of child health to have a sense of the type of knowledge that fathers have regarding health related issues. This section examines what fathers know regarding threats to child health and treatments.

For fathers, child health was clearly a major concern. One father explained:

*I lost one of my children to pneumonia. I don’t want to lose my other children to diseases.*

The major child health related concerns of the respondents and the focus group were dirty water, poor sanitation, cleanliness, food and nutrition, inability to afford health care, unreliable doctors and lack of adequate treatment in public hospitals.

4.3 Fathers’ understanding of child diseases

| Table 2: Diseases which are believed to be dangerous for children by informants and Focus group$^{10}$ |
|---|---|
| Diseases | Number of informants expressing concern about this disease |
| Diarrhoea | 13 |
| Vomiting | 8 |
| Pneumonia | 7 |
| Typhoid | 7 |
| Fever | 5 |

$^{10}$ The design for this table comes from the findings of Jahn and Alam (1995, p. 198).
As we can see from Table 2, all thirteen respondents were concerned about diarrhoeal diseases, which, for the most part, are a result of dirty water and bad sanitation. Vomiting, which is also associated with dirty water and bad sanitation and is accompanied by diarrhoea (locally, dan wa daman), was perceived by fathers as the second most dangerous health threat for children. Typhoid was also perceived by seven fathers as serious threat to children’s health. Fathers also perceived other diseases such as fever, measles and the common cold as posing some dangerous health threat to children.

According to WHO:

*Diarrhoea occurs world-wide and causes 4% of all deaths and 5% of health loss to disability. It is most commonly caused by gastrointestinal infections which kill around 2.2 million people globally each year, mostly children in developing countries.* (WHO 2011, p. 1)

4.4 Fathers’ Understanding of their children’s deaths

<table>
<thead>
<tr>
<th>Interviewed Fathers</th>
<th>Education</th>
<th>Occupation</th>
<th>Number of Surviving Children</th>
<th>Number of Deceased Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Illiterate</td>
<td>Tailor</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Illiterate</td>
<td>Dish Rental Shop</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>Illiterate</td>
<td>Shop Keeper</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>Illiterate</td>
<td>Shop Keeper</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Illiterate</td>
<td>Day Labor</td>
<td>3</td>
<td>-</td>
</tr>
</tbody>
</table>
During the interview with respondents,\textsuperscript{11} it was found that a number of fathers had lost children under five to different diseases. Some fathers stated that they did not know their children’s causes of death. As one father explained:

\textit{I lost five of my children to unknown diseases. They all died during their first or second day of life. When each of my children was born, they would start hiccupping and then would go green after that they would die. Even two of them were born in the hospital. I took them to doctors and the hospital. It didn’t help.}

Another respondent recounted:

\textit{I lost four of my children, at the ages of 3 months old, 10 days old and 1 year old, to sickness from sofian [a type of Jinn\textsuperscript{12}] sicknesses. First I took them to...}

\textsuperscript{11}The author recognizes that the number of respondents is small, making a small sample number, which cannot be seen as representative of the population at large. However, this small case study has been indicative that the topic requires further examination.
the sofian shrine, but it didn’t help. One of my children was in the hospital for three months, but it didn’t help... the doctor told me that the cause of my children’s death was malnutrition. After my children died, I went to the Mullah, and he gave me a tawis [a surah of the Koran]. After that, my children were born healthy.

Another respondent said:

I lost two of my children during winter time to pneumonia. Because of the bad security at that time I couldn’t take them to hospital or a doctor. I tried traditional medicine, which I had at home, but it didn’t help. One of my children died at the age of one and half years old and the other at the age of 6 months.

A tailor said “I lost one of my children to pneumonia. Just because of the doctor’s prescription. The medicine and the injection that he gave was the wrong one and that was the cause of my child’s death.”

4.5 Fathers’ roles in child health

When I come home from work in the evening, I look at my children and all my tiredness goes away, a tailor and resident of Bibi Mahru settlement stated.

Most of the respondents and the focus group participants said that it is a mother’s responsibility to look after children. They felt that ‘as fathers it is our duty to ask children about their daily activities and their study.’ This was confirmed by respondents. However, fathers also indicated that in practice they do spend time looking after their children’s needs.

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12 A “Jinn” is a type of a spirit, spoken of in the Koran as a creation, created by Allah from fire. In Afghanistan, people believe that it can get inside your human body and affect one in a number of ways, including giving illness.

13 The International Committee of the Red Cross confirms that it was difficult for civilians to access medical care during periods of conflict. “The fighting is depriving civilians of basic services such as health, because medics can’t get into remote areas and people can’t get to the towns where the medics are. Pregnant women often spend days trying to get to a hospital because there are no health facilities nearby,” (ICRC, 2009)
One father said, “When my wife was in the hospital with my daughter, I took care of my children at home.”

The one unemployed father from the respondents explained how he shared childcare with his wife. He said that “While my wife is working and I have no job, I take care of my children. I bathe my children. I change their clothes. I cook for the family and I often tell my children to use soap.”

In general fathers explained that they take their children outside to try to give them some entertainment. For example, some fathers said: “If we are not too tired we take our children out to local shops.” From informal observations at a bus stop in the street, it was also found that the majority of fathers were carrying their children, while their wives were next to them.

Apart from the father’s main role as a breadwinner of the family, fathers felt they have a direct role and responsibility to make decisions concerning their children’s health. From comments in the focus group about who makes the decisions in child health, it was clear that the fathers felt that usually men in Afghan society are the decision-makers. However, some informants said things such as: “Life is shared between a wife and a husband and decisions should be taken together, especially about child health. Although, if the need arises, my wife can take children to the doctor any time.”

Another respondent said:

I often discuss with my wife our children’s health, even when I am at work, I call my wife two or three times a day asking about the children. Every evening when I go home, I ask my wife how are the children.

On making decisions regarding taking a child for medical care, focus group participants agreed that “While we are at work, if it’s urgent that a child should be taken to a doctor, yes my wife can make the decision.”

Fathers said that they discussed their child’s health with their wives, including the need to take children to the clinic or hospital. As one respondent said, “life is shared between a husband and a wife. My wife can take the children to their immunisations and for other reasons to the local clinic.”
Fathers considered that it was their job, rather than the mothers, to take children out. However, it was seen as acceptable for mothers to take their children to the local clinic, which focused on mother and child health issues. All of the respondents had no objection to their wife taking children to the local clinic. As one respondent said, “my wife is allowed to take the children to the local clinic.” However, most respondents and participants of the focus group felt that if a woman was to take her children to hospitals or doctors, she should be accompanied by a male relative (or ‘mahram’).

All respondents stressed that decisions on immunisations and vaccinations are a joint concern of both fathers and mothers. They felt that both parents had a responsibility to make sure children had all their vaccinations. Most fathers said that they themselves took responsibility to make sure their children were vaccinated.

Although, fathers feel they are the main decision makers in their household, most of the respondents said that both father’s and mother’s decisions should be obeyed in the family.

4.6 Fathers’ perception of their role in the family

My children are the most precious human beings for me. Whatever it takes for me, I will provide them with food.

Shop keeper in Bibi Mahru, one of the 13 fathers interviewed.

“The first thing every father has to do is provide his children with food.”

Tailor in Bibi Mahru, one of the 13 fathers interviewed.

Fathers defined their role as primarily a wage earner and material provider for their families. They considered that they must provide the basic needs of the
family, such as food, shelter, medicine, books and other needs for school and a healthy environment. They also highlighted their role in teaching children good behaviour.

Most of the respondent felt that they have close relationships with their children. Some indicated that they felt particularly attached to their daughters, feeling that “girls are innocent.”

Apart from providing food to the families, fathers felt that another important obligation was teaching children respect and to behave well, as well as encouraging them to pursue their education. The teaching of good manners and education was equally important among educated fathers and non-educated fathers. Most of the fathers felt that “children should respect their elders and do their school work, as well as go to the mosque for Islamic study.”

4.7 Fathers’ perception of mothers’ health

Although the major concern of this study was to find out about fathers’ perception of their children’s health, since maternal health is closely related to child mortality and health (see below) the issue of mother’s health has also been discussed with some of the respondents and in the focus group.

One of the respondents said, “At the moment my wife is pregnant, I took her four times for an ultra-sound check to see whether the baby was in the right position in mother’s womb.” Another respondent father said, “Of course my wife’s health is important for me. When my wife was sick I took her to several doctors here in Kabul, but it didn’t help. Then I took her to Pakistan and showed her to the doctors there. Now she is better.”

It is interesting to note that the fathers’ perception of their role in the family corresponded with the view of the local mullah as to what the role of a father should be. He said that from an Islamic perspective, “a father has a direct responsibility to his children. He should make sure that they are fed, given education, given Muslim names. If a father doesn’t carry out his responsibilities towards his children, it is a sin and he will be held responsible in the afterlife.” He particularly emphasised the responsibility of a father to provide food for his children.
A shop owner said his financial situation “is not that good to take members of my family, including my wife, to doctors. We try to treat sicknesses with traditional medicine. If that doesn’t help, I will take my wife to the doctor.”

The fathers who discussed their wives’ health all agreed that it was as important as their children’s health. However, in most cases, it was father’s income and economic situation that played a significant role in whether they could seek proper medical care for their wives.

4.8 Fathers’ perception of cleanliness of physical environment

Fathers were concerned about the physical cleanliness of their environment, from rubbish in the streets, to insect infestations to poor drainage. The focus group participants complained that they did not receive government assistance to help ensure a safe, healthy environment. For example, a focus group participant said that they “don’t get any assistance from the municipal council (locally known as ‘sharwalee’) to take garbage from our streets.”

A respondent complained about flies in the area and was concerned that ‘flies are a major cause of disease being spread in our area.’ Most fathers felt that many diseases were related to the lack of cleanliness of their physical environment in Bibi Mahru. As one father said:

*Rubbish, filthy standing water and bad drainage is leading to too many diseases, increasing mosquitoes, malaria, flies, diarrhea and skin diseases.*

Most fathers stressed that they often make sure that the household’s physical environment is clean for their families. Most fathers explained that they try to protect their families from flies and mosquitoes by installing mosquito nets on the windows. They considered that cleaning the house is a women’s job, but when it comes to heavy physical work then it is their job. For example, some fathers explained that they “put concrete around the well to make sure that the well is not absorbing the surrounding water.” Another explained that in order to keep his house clean and get rid of germs, he puts lime on the wall of his house.

On water and sanitation issues, most respondents and the participants of the focus group described their water as ‘contaminated’ with human faecal matter and felt that
dirty water was one of the major health threats to their children. One of the respondents said:

Water is a major health issue for our children. Although we try to boil water and give children tea, we can’t control children all the time. They do drink this dirty water and it makes them sick.

In the focus group discussion another said:

If we had a little assistance from the government or local municipal council, we could find a solution to our sewage system. It would reduce many diseases. Even though we asked the local municipal council for assistance many times, no one comes to look at our problems.

The head master of the Bibi Mahru School also raised concerns regarding clean drinking water. He said:

We tested our school water and it showed that the water is unsafe for drinking. We told the Ministry of Health and the Ministry of Education that we need to dig the well deeper, at least another 10 meters to get clean water, but we never heard from them. Our school children still use the school well water for drinking.15

Fathers are clearly concerned about the physical environment in which they live and that it does not support their children’s or family health. They appear to feel somewhat powerless to change the situation and feel that they are not receiving appropriate support from government to improve the health environment. In relation to the lack of clean water, although they recognise that it is a threat to their children’s health, they do not appear to recognise how serious it is. From researcher observation, it was seen that fathers do allow their children to drink it.

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15 Unsafe water and poor sanitation has a direct impact on children’s health, leading to diseases such as cholera, typhoid, diarrhoea, dysentery, bacillary and gastroenteritis. Diseases arising from unsafe water and poor sanitation are responsible for more than 4 per cent or 1.8 million of all under five deaths (WHO 2, 2011).
4.9 Fathers’ perception of poverty: food and nutrition, ability to afford health care

In the focus group and the individual interviews with fathers, poverty was seen as a major impediment to ensuring good child health.\textsuperscript{16} Fathers were particularly concerned about poor nutrition, high doctor fees, the unhealthy physical environment and difficulty in accessing adequate health care.

Many fathers were concerned about their ability to buy nutritious food for their children.\textsuperscript{17} For example, a shop keeper stated: “Life is unbearable. It is very hard for us... If I had enough income, I would feed my children better food. What I earn now is not enough to feed my children good food, and buy the children’s school stationary.” Fathers indicated that they were the person in the household, rather than mothers, that do the food shopping for the family, and therefore had a direct relation to provision of nutritious food for the children.\textsuperscript{18}

Fathers felt that poverty was also a factor in accessing quality health care. Fathers said that unless they had more money, they were not able to access proper medical care. One respondent described that “most of the doctors are only working for money. If you give them money they will treat your child properly. If you can’t give them enough money they will not look at you.’

People felt that they were also not receiving government services because of their poverty. They said that the government was not assisting them to make improvements that would have positive impacts on child health. Participants in the focus group spoke about marginalisation because of poverty in the following terms:

\begin{itemize}
\item Child mortality is closely related to poverty. The reduction of child mortality has been considerably slow in poorer countries and in the poorest population of the wealthiest country (The global poverty project, 2011: 1). Afghanistan is one of the poorest countries in south Asia, with almost 9 million people, 36 per cent of the total Afghanistan population, living in absolute poverty and not able to meet their basic needs of life (OHCHR 1, 2010a).
\item Malnutrition was a real consequence of fathers’ not providing their children with sufficiently nutritious food. As seen above, a doctor told one father that three of his children died from malnutrition.
\item In Afghanistan, it is the norm that men will do the household shopping, rather than the women.
\end{itemize}
No one comes from the government to look at our situation. Aid never will reach our area. We know that a lot of aid money is coming to Afghanistan, but it has been shared among the rich people in the government.

4.10 Fathers’ concern about the health system

Fathers showed a great concern both in interviews and in the focus group about the quality of the health system in Afghanistan. Most of the fathers agreed that if a child is sick they should be taken to the doctor. However, some respondents agreed that “these doctors don’t know anything. They never give proper medicine to our children.” As an example, one respondent said that doctors had given his child the wrong treatment for pneumonia and his child had died. Although it is not clear whether this was actually the case or not, it indicates a lack of trust in the medical system and a sense of powerlessness on the side of the fathers to influence and understand it.

Although many fathers in the focus group and the interviews said that they take their children to government hospitals when their children are sick, most fathers expressed concerns about the quality of care. Focus group participants said:

We can’t afford to take our children to private hospitals, but when we go to the government hospitals, we have to wait for a long time to see the doctor. After all of this waiting, we don’t get proper care. If we give money to doctors, they will look at our child. If we can’t offer to pay them, they don’t pay proper attention to us.

One father went on to say:

In the hospital when we need blood either we have to pay for it or they will take blood from us and give it to children.

19 The fathers’ concerns are backed up by other literature, which has found that the “health system is facing critical challenges related to the political, social and economic determinants of health and the performance of the health system functions” (WHO 2006, p. 2).
4.11 Summary of findings

The research appears to indicate that the fathers interviewed have a close connection both physically and emotionally to their children. They care for and love their children. They are worried about their children’s health and their children’s deaths had a significant emotional impact on them. Apart from their main role in the family as an income and resource provider, many of the fathers were engaged in child caring activities and all took on a significant role in decision-making in their families, particularly in relation to their children’s health.

Fathers of Bibi Mahru area are poor people and feel that they don’t receive any assistance in their role of supporting their families’ health. They feel that the medical system does not support them, they do not receive support in providing clean water and sanitation, and their economic situation makes it very difficult for them to feed their families and ensure a safe, clean environment.

Although the fathers had a range of educational levels, overall, many of them, irrespective of their education, did not appear to have a sufficient understanding to assess the seriousness of diseases or the required responses to ensure the health of their children. Some of the fathers did not know the causes of their children’s deaths. Others knew the causes, but had not been able to take sufficiently appropriate action in time to remedy them. In describing their perception of unclean water as a threat to child health, although fathers knew that it was a threat, they did not seem to fully comprehend the seriousness of the issue. Although they preferred their children to drink clean water, they admitted that their children did drink water that was not clean and safe for drinking.
5. The global context of reducing child mortality

In order to understand the significance of the findings in Bibi Mahru, it is necessary to have a picture of child mortality both globally and within Afghanistan. Below, the paper examines the global scale of the problem, the results of global efforts to reduce child mortality and the regional variations in South Asia. As will be seen, efforts to reduce child mortality in Afghanistan have not compared favourably to progress made in much of the rest of the world.

In 2009 alone, it is estimated that 8.1 million children under the age of five died worldwide, which is the equivalent to 22,000 children under-five dying every day or 15 children every 15 minutes. Overall, 15 developing countries account for 70 per cent of deaths of children under-five; Sub-Saharan Africa accounts for nearly half and southern Asia for a third of the under-five deaths. More than one-third of these children die during the first months of life, often at home and without professional medical care (You, Jones & Wardlaw, 2011).


Figure 1 (UNICEF, 2010, as cited in Global Issue 2011).

Since 1990, many developing countries have made significant progress in reducing child mortality. This is reflected in the global reduction of child mortality per 1000 live births from 89 deaths in 1990 to 60 in 2009. Sub-Saharan Africa, South Asia and
Oceania are the only regions that have failed to reduce child mortality by at least 50 per cent. Therefore, worldwide child mortality has declined by more than 30 per cent or in absolute figures from 12.4 million in 1990 to 8.1 million in 2009 (You, Jones & Wardlaw, 2011).

![Figure 4: Under-five mortality declined in all regions between 1990 and 2009](image)

Figure 2 (You, Jones & Wardlaw, 2011, p. 7).

As can be seen from figure 2, the achievement in reducing child mortality has not been consistent throughout developing regions. Some regions have achieved significant reductions, while others have not. Similarly, we also see disparities within regions in the progress of individual countries. South Asia, from 1990 to 2009, took second highest place by region in under-five mortality, despite the reduction in child mortality from 123 to 69 deaths per 1000 live births. Afghanistan, Pakistan and India have half of the world’s undernourished children.

However, at the same time, some countries in South Asia have made significant progress. For example, from 1990 to 2009 Bangladesh managed to reduce its child
mortality by more than 60 per cent, or an annual rate of 5.5%. This is equivalent to a reduction from 148 deaths per 1000 in 1990 to 52 deaths per 1000 in 2009 (You, Jones & Wardlaw, 2011).

6. Child mortality in Afghanistan

High child mortality is not a new trend for Afghanistan. Historically, it has had one of the highest rates of under-five child mortality in the world. In 1960, under-five child mortality was estimated at 360 per 1000 live births. In other words at that time, Afghanistan’s under-five mortality rate was 30 per cent higher than the average of developing countries and more than 60 per cent higher than the average of developed countries (MDG, 2005).

Around the world a handful of diseases are responsible for 80 per cent of the deaths of children under five. They include neonatal disorders, pneumonia, diarrheal and malaria. Nutrition is also responsible for over a third of deaths (Black et al., 2008). In Afghanistan, the picture is similar, with nearly 60 per cent of deaths of children under five years of age resulting from diarrhoea, acute respiratory infections and vaccine-preventable diseases. Cholera outbreaks are frequent during the summer and the spread of diarrheal among children is very high (MDG, 2005).

The Government of Afghanistan has committed to the Millennium Development Goals, including Goal 4 to reduce child mortality. Globally, countries recognised that high rates of child mortality were a core development issue and committed to reducing the child mortality rate by 50 per cent from 1990 data by 2015. In 1990, globally around 13 million children under the age of five died from a handful of diseases such as neonatal disorders, pneumonia, diarrhoea, malaria and HIV AIDS. Most of the deaths occurred in developing countries (World Bank, 2011).

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20 This paper uses the World Bank definition of under-five child mortality: "Under-five mortality rate is the probability per 1,000 that a newborn baby will die before reaching age five, if subject to current age-specific mortality rates" (World Bank 2010 p.1).
21 The Millennium Development Goals (MDGs) were adopted by the General Assembly of the United Nations on 18 September 2000, at the UN Millennium Summit. Since 2000 around 190 countries have endorsed the resolution. The aim of the resolution was to obtain the commitment of developing countries to achieve eight key Goals and its 18 targets within their respective countries by 2015 on the basis of 1990 baseline data (Desai and Potter 2008, p. 30)
In 2000, Afghanistan was under the control of the Taliban and did not participate in the United Nations adoption of the MDGs. Four years later, however, the new Afghan Government decided to commit to achieving the MDGs. Given the situation in Afghanistan, though, the Government felt that it was not realistic to achieve the MDGs by 2015. In addition, there was no 1990 data to use as a baseline, in line with other countries. Therefore, the Government decided to commit to achieving the MDGs by 2020, on the basis of baseline data from 2002 and 2004 (UNDP, 2011). On Goal 4, the Government committed to reducing the level of child mortality by 50 per cent between 2003 and 2015 and then to a third of the 2003 level by 2020 (MDG 2005).

At the same time, it began the development of a national development strategy, which was launched in 2008 (MDG, 2005). The Afghan Government in its Afghan National Development Strategy 2008-2013 (ANDS) has given a high priority to the issues of child health and maternal health, including quality reproductive health, improving health care services, counselling and modern family planning services. It focuses on reducing child mortality, morbidity, improving child growth and vaccination rates and addressing adolescent health though school health programmes (Islamic Republic of Afghanistan, 2008). However, in the (ANDS), the role of fathers or their involvement in child health was not mentioned.

Despite the Government’s intentions, as outlined in the ANDS and its 2004 commitment to reduce child mortality by 2010, Afghanistan remained ranked amongst those countries with the highest child mortality rates in the world. From 1990 to 2009, Afghanistan has reduced child mortality annually by 1.2 per cent. However, this progress has been considerably slower compared to other developing countries.

6.1 Afghanistan, Education and Child Mortality

Afghanistan is one of a group of developing countries with the lowest rates of literacy in the world. These countries include Chad, Ethiopia, Sierra Leone, Somalia and Yemen. The literacy rates are low for men and even lower for women. In the last

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22 Despite the fact that Afghanistan faces serious challenges in achieving most of the MDGs, including those relating to extreme poverty and health, the Afghan government in any case added security as a 9th goal under the MDGs. The Afghan government considered that unless the country achieved security, then none of the MDGs would be achievable (MDG 2005, p. 136).
forty years, these countries only increased the average level of schooling for females by only two years (Brown, 2010).

We see in figure 3 how the adult literacy rate for Afghanistan compares to other least developing countries.

![Figure 3](UNDP, 2007 p. 23).

As we can see from this graph, that Afghanistan’s adult literacy rate is only slightly above that of Burkina Faso and Mali. UNDP has found that for Afghanistan the adult literacy rate is only 23.5 per cent. Other data indicates that the female literacy rate is significantly lower, although the exact figures are hard to know. However, the rates are not consistent across the country, with urban centres having much higher rates of literacy. Lee estimates that female literacy rates in rural areas are eight times less than in urban centres (Lee, 2002, p. 11).23

Since studies have found a correlation between mothers’ and fathers’ education levels and child survival rates, it is worth comparing literacy rates in these developing countries with child mortality rates. In Mali, where the adult literacy rate

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23 Other data indicates a different rate in 2001, with the overall adult literacy rate in Afghanistan estimated at around 36 per cent. For adult women, it was only 21 per cent (EFA, 2001 as cited in World Bank, 2005b). For 2008 data indicated that the adult literacy rate was in total 28 per cent. Women's literacy rate stood at about 15 per cent, while the male rate was about 31 per cent. (Mashal and Takona 2008, p 4).
is only 19 per cent, the child mortality rate is 191 deaths per 1000 births. In Burkina Faso and Afghanistan, where adult literacy rates are 21.8 per cent and 23.5 per cent respectively, the child mortality rates are 166 per 1000 live birth in Burkina Faso and 199 per 1000 in Afghanistan. We see that the countries with the lowest adult literacy rates are, similarly, those with the highest rates of child mortality (You, Jones & Wardlaw, 2011, pp. 11-13).

In Afghanistan, the Government has recognised the importance of improving education and literacy rates in the country. In particular, through the Afghan National Development Strategies, it has emphasized the need to increase the literacy rate of girls (Afghan National Development Strategies 2008, p. 113). However, for now the literacy rate in Afghanistan remains one of the lowest in the world and, as discussed further below, could be a significant contributing factor to the high rate of child mortality.

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24 Since the fall of the Taliban regime in 2001 millions of girls have been back to schools, from 5000 under the Taliban regime to 2.5 million by 2010 (Ayobi, 2010). However, OXFAM suggests that “the gains made in improving girls’ education are in danger of slipping away,” (OXFAM, 2011). Many girls are dropping out of school because of “poverty, insecurity, lack of trained teachers, neglect of post-primary education and poorly equipped schools,” (OXFAM, 2011).
7. Gender: women’s position in Afghan society

It is important in the context of examining fathers’ perception of child health in Afghanistan to understand the gender context in the country and to see how men and women are placed within society and can influence child health within the context of the family. As will be seen below, restrictive gender roles can be strictly imposed and women’s status is often low. In general, women are marginalised; women’s movement is restricted in the community; and they have very limited ability to make decisions within the community and the family. It has been well established globally that discrimination against women, one form of inequality and exclusion, has led to worse health outcomes for children (Freedman et al 2005). This inequality between the sexes impacts on the approach taken to child health within the family and it becomes highly relevant when looking at the father’s perception of child health.

In Afghanistan, gender differentiated roles, behaviour, activities and attributes of men and women have led to gender inequality. Discrimination against women in Afghanistan is perpetuated in many forms. It includes girl child marriage, in which girls from ages ten to fifteen are given or sometimes sold to a husband. Girls are also given away as a form of compensation in dispute resolution between families or tribes. Older girls and women can be confined to the home by other family members, denying them access to education, work and health care. “Honour” killings of girls and women who are considered to have brought shame on the family also occur in Afghanistan. Those that step outside of social restrictions, many expect to face social stigmatisation at the best and threats and murder at the worst (Office Of The High Commissioner for Human Rights, 2009 and Office Of The High Commissioner for Human Rights, 2010b). The strict gender roles in Afghanistan affect women and men differently in terms of their social status and decision-making power and also have very practical effects in terms of development outcomes and access to services such as health, education and welfare. This, in turn, directly affects maternal and child mortality rates in Afghanistan.

Over the past 100 years, the issue of gender equality has been highly politicised. Men who have been active in politics, religion and communities have held strong views on gender equality. Since the 1880s, the rulers of Afghanistan have tried to bring in reforms to modernise society, including through changing the traditional roles of
women in society. However, in each case reforms have met strong opposition, which on several occasions was strong enough to bring down the rulers, along with their reform agenda.

King Habibullah ruled Afghanistan from 1901 to 1919. He continued reforms started by his father in the late 1880s, to empower women and not confine them only to the home. He opened a school for girls and promoted female education, as a part of a programme of promoting modern education. His wives appeared in public unveiled. He supported modern media, including a newspaper that had a section devoted to women’s issues that was edited by a woman. He tried to reduce the amounts spent on weddings in an effort to reduce poverty. However, these reforms led to his ultimate demise. As Ghosh states:

*Education for women, and state’s interference in marriage institutions challenged the power of tribal leaders and their patrilineal and patrilocal kinship systems, resulting in Habibullah,s assassination in 1919.* (Ghosh, 2003 p. 3)

In 1923, King Ammanullah again tried to bring in reforms for social equality of women, including the elimination of purdah (separate confinement and covering of women), a campaign against polygamy and increased education of girls in all provinces of Afghanistan. However, again showing the strength of social views on these issues, Ammanullah’s reform agenda led to the collapse of his kingdom in 1929.

In the 1970s, the leader of the Afghan People’s Democratic Party of Afghanistan (PDPA), backed by the Communist party, pushed for social reforms to empower women. This included the elimination of the bride-price, mass campaigns towards literacy for men and women, raising the age of marriage and equal legal rights for women (Ghosh, 2003, p. 2). However, these reforms were again opposed, being seen as interference in Afghan culture, and led to a counter campaign, which included incidents of attacks and shooting of women, and general harassment of women increased.

In the end, the PDPA collapsed in 1992 in the face of a national and international campaign, particularly backed by the US, to bring down the Soviet backed
government. In the period directly after the mujahedeen came into power. Although, the mujahedeen did not restrict women from work, or formally limit their freedom of movement, they did force women to cover themselves from head to toe. In practice, their freedoms were limited further due to mass violations against women during the period 1992 to 1996 (Zoya, 2002, as cited in Ghosh 2003, p. 7 and Dorronsoro, 2007, p. 2). According to Amnesty International in 1995:

*Women and girls all over Afghanistan live in constant fear of being raped by armed guards. For years, armed guards have been allowed to torture them in this way without fear of reprimand from their leaders. In fact, rape is apparently condoned by most leaders as a means of terrorizing conquered populations and rewarding soldiers.* (Amnesty International 1995, p. 7)

During the Taliban period from 1996 to 2001, women benefited from increased levels of security in the country (Kawun Kakar, Institute for Afghan studies, 2000). However, at the same time, they were denied education, employment, freedom of movement, access to medical care and other basic rights (World Bank 2005b, p. 5). For the most part, women were not allowed to move outside of the house without a male relative accompanying them; girls were no longer allowed to go to school, nor women to work. Strict dress and behavioural codes were imposed and women who transgressed these risked beatings or other forms of punishment. Most of the restrictions imposed upon women during the Taliban period came from the cultural context, in which education, independent movement and employment for women were discouraged. However, the Taliban imposed these restrictions through the force of the state and restricted the rights of women more consistently and thoroughly than had been the case through cultural restrictions alone.

The thirty years of conflict in Afghanistan have significantly impacted on women’s position in society. During the years of civil war, women suffered very serious human rights violations. Indicators show that during this period, women in Afghanistan suffered from the highest levels of health and social inequities in the world. Concerns over women’s security led to the imposition of stricter social behaviours on women. Male heads of households often felt impelled not to allow women out of the home, in order to defend their honour and reduce the risk of attacks against women. The Taliban’s gender policies from 1996 to 2001 imposed
significant restrictions on women, confining them to the home and limiting their rights. By the end of the Taliban period, international concern over women’s rights issues had peaked and led to a strong push by the international community, supported by some parts of Afghan society, to address issues of gender equality after the fall of the Taliban in 2001. This led to women’s rights issues being highlighted during the peace process and following efforts by the Government of Afghanistan and donors towards women’s equality. Legal improvements were put in place, including through the constitution (Wakefield & Bauer 2005, p. 1).

On the policy level, the Afghan Government in its Afghan National Development Strategy Plan (ANDS) includes gender equality:

*The ultimate goal is ‘gender equality’; a condition where women and men fully enjoy their rights, equally contribute to and enjoy the benefits of development and neither is prevented from pursuing what is fair, good and necessary to live a fully and satisfying life.* (Afghan National Development Strategy 2008, pp. 147-148)
8. Women’s Health

It is important to examine women’s health and its links with child health, since a father can influence both through his decision-making and behavior. The state of women’s health in a country is also an indicator of discrimination against women in society, which will be reflected in the home. When women’s health is overlooked or ignored, women’s health indicators will reflect this. A father who is supportive of his wife and promotes her health will be indirectly promoting the health of his children. Conversely, a father who discriminates against his wife will be negatively affecting the chances of positive child health outcomes.

*While life expectancy is higher for women than men in most countries, a number of health and social factors combine to create a lower quality of life for women. Unequal access to information, care and basic health practices further increases the health risks for women.*  
(WHO 2011a, p 1)

Globally, discrimination against women has led to women facing many health hazards such as those caused by sexual and physical violence, sexually transmitted diseases and other diseases. In developing countries, pregnancy and birth related mortality is still very high and the failure of health systems to provide adequate and appropriate maternal health care can also be considered a form of discrimination against women (WHO 2011a).

Discrimination against women is reflected in poor health outcomes for women in Afghanistan. Notably, Afghanistan stands out in contrast to most countries in the world by having a female life expectancy that is shorter than the male life expectancy. On average, an Afghan woman’s life expectancy is 42 years, over 25 years shorter than the world average lifespan and 2 years shorter than the average Afghan male (Parliamentary information and research service 2008, p. 2).

Afghan women suffer from amongst the highest maternal mortality Rates (MMR) in the world, meaning they are at very high risk of dying during pregnancy and child birth. Out of 100,000 live births, 1600 women will die. In comparison, the death rate of women in Iran is only 76 per 100,000 live births. Sierra Leone is the only country with a higher rate at 2000 per 100,000 live births (UNDP 2007, p. 27).
As can be seen from the figures for some remote areas of Afghanistan, such as Badakshan province, the rate is even higher, estimated at 6500 per 100,000 live births. In such remote rural areas the high rate appears to be directly related to the “profoundly limited” access to health care (World Bank 2005b, p. 14).

There are many factors leading to the high MMR in Afghanistan. The World Bank states: “Besides the lack of access to and quality of health services, other factors such as a lack of adequate food, shelter and clean water, low marriage age, high fertility rate and the lack of spacing of child births contribute to the extremely poor health of Afghan women” (World Bank 2005b, p. 13). Women have a very low access to skilled health personnel, at only 1 skilled personnel available per 5000 women.

High rates of maternal mortality have a significantly negative impact on children, families and communities as a whole. In particular, the impact on child survival is enormous. Evidence from across the world shows that when the mother of a new born infant dies, the infant has "only one chance in four of surviving until its first birthday” (World Bank, 2005b, p. 14 and UNICEF 2008, p. 2).

A study in four provinces of Afghanistan, Kabul, Lagman, Kandahar and Badakshan, found that “if a newborn’s mother died of maternal causes, the baby had only one chance in four of living until its first birthday. Most of these infants died in the first month of life from acute malnutrition due to lack of breast milk” (Bartlett & Mawji 2002, p. 6). 25

It can therefore be surmised that one of the reasons for the high child mortality rate in Afghanistan, is the high maternal mortality rate. In examining a father’s perception of child mortality, it is therefore relevant to look at a father’s perception of his wife’s health.

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25 Research in Nepal also had similar findings that maternal mortality was closely associated to infant mortality. The study found that an infant whose mother died had a 52 per cent increased chance of dying between its fourth and twenty-fourth week of life, compared to children whose mother survived (Katz, West & Khatry 2003, p. 719).
9. Women and development and decision-making

The role of women in decision-making in Afghanistan illustrates the gender inequalities in the country and limits that are placed on women. A father’s perception of child health can be influenced by these social norms and affect the decisions that he makes regarding child health and the interrelated issue of maternal health.

One piece of research on mother’s autonomy and decision-making in relation to child health in Afghanistan has indicated that females have little influence on most decisions in the family, which are typically made by men, including those which relate directly to child health (Mashal & Takano, 2008 p. 11).26

Studies in other countries have indicated that when women are involved in development, they contribute more to household incomes and positively influence the well-being of the family (ADB, 2001, p. 1, Desai & Potter 2008, p. 341).27 In Afghanistan, a study on women who were involved in micro-credit programmes indicated that women who contribute to household incomes have an increased influence over family decision-making, including around decisions affecting their children (Afghan Management and Marketing Consultant, 2011, p. 24).28

In another study, it was noted that communities did not feel that women were well equipped to be involved in development processes or decision-making beyond the

26 Mashal and Takano argue that “high child mortality rates in conservative Afghanistan are linked not just to war but to mothers being uneducated and having little or no say when their children need medical help” (Mashal & Takano, 2008, p. 11).
27 In Bangladesh, studies have shown that women’s involvement in development does not only help to provide income for their households, but also improves the broader national economy. Women provide the labour force in industries that amount to 70 per cent of the country’s export income. Over 8 million women are self employed through the support of national and local development organisations (ADB, 2001, p.1). Desai and Potter explained in more detail how women having an income impacted positively on the well-being of the family. They found that women’s income is directly spent on household needs and wants, whereas a considerable portion of men’s income is spent on their personal needs. They also found that when women have better educational and employment opportunities, later in life they rely less on their children’s income and are more self-supporting (Desai & Potter 2008, p.341).
28 A study was carried out in four provinces- Kabul, Nangarhar, Balkh and Herat- to assess the impact of women’s involvement in micro-finance programmes on women’s economic situation in the household, her empowerment and influence on decision-making. A sample of 800 households was selected in the four provinces. It found that women who were employed through the micro-credit programme were ten to fifteen per cent more likely to participate in family decisions, such as whether children should go to school and decisions around the marriage of their children, compared to women who were not a part of the programme and presumably not earning an income (Afghan Management & Marketing Consultant, 2011, p 24).
immediate household sphere. Communities indicated that women’s knowledge is “incomplete” and that they don’t know anything about developmental activities. For example, in northern Afghanistan, Panjao villagers told researchers that they were allowed to talk to their women but they warned them that “women do not know anything.” When researchers spoke to the women, the women themselves stated that they lack knowledge to make decisions (Wakefield & Bauer 2005, p. 5). This situation may reflect a lack of respect for women’s ability to make decisions. It may also reflect the fact that women do not receive the levels of education and exposure to community issues as men do. Either way, women are clearly at a disadvantage. It may also reflect broader attitudes towards women in Afghanistan, and in that sense is relevant to the decision-making processes that happen in households between mothers and fathers.29

As a part of Government efforts to promote women in the political, economic and social spheres of life, the Government has been promoting women in public positions of decision-making.30 Through the ANDS, high priority is given to promoting opportunities for women to participate in development activities and decision-making. It says that in order to enable participation of women in governance, it will promote affirmative action programmes for women. It highlights the need to create an environment where women can have decision making power. It states:

All government entities will: (i) foster a work environment that supports egalitarian relationships between women and men; (ii) establish internal enabling mechanisms for gender equity; and (iii) support women’s shuras. (Afghan national Development Strategy 2008, PP. 147-148)

Since 2001, some women have returned to the workforce, including in areas such as teaching, medicine, the civil service and media. Development activities have

29 A study by OXFAM recognised the complexity of decision-making on certain issues in the household in Afghanistan, stating that “decision-making around whether or not girls go to school, and how long, is complex and extremely varied from province to province and even household to household,” (OXFAM 2011, pp. 4-5).
30 Wakefield and Bauer argue that the foundation for these efforts has been a belief that both men and women should have equal opportunities and rights to participate in development and decision-making (Wakefield and Bauer 2005, p. 3).
supported the training of women with new skills, including in the area of setting-up their own small businesses (Wide Angle, 2006).  

Development activities have also supported the participation of women in shuras. A shura is a traditional form of local council that can make decisions, create local rules and mediate local disputes on a range of economic, political and sometimes social issues. The ANDS has emphasised the need for engagement with local shuras. The Government’s strategy has been to create some 18,000 Community Development Councils (CDCs) to implement community led development projects. The projects provide local access to financial and human resources such as grants and technical assistance to provide basic services such as water, roads and schools. The CDCs are encouraged to cooperate closely with village level shuras. The ANDS stresses that the CDCs are designed to include female and male members. However, in general, women’s participation and representation has been excluded in the shura in practice. Studies in 30 communities found that only 3 women participated in the joint male and female CDCs (Wakefield & Bauer, 2005, pp. 4-5).

Overall, it is clear that although policies have been put in place to involve women in decision-making, progress has been limited. Communities remain hesitant to allow women into the publicly visible positions of employment and decision-making. This point was emphasised in a human rights report that documented attacks against women who took up employment in high profile positions. The report also pointed to intense family and community pressure on women to refrain from working and remain in the home (Office of The High Commissioner for Human Rights, 2009 and Office of the High Commissioner for Human Rights, 2010b). At the same time, it appears that women who do receive opportunities to be involved in development, and in particular those that earn an income, are more able to be involved in household decision-making. Both of these factors are relevant in looking at decision-making of

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31 Donors have particularly promoted the use of microfinance activities among the Afghan women. Out of 434,095 microcredit clients in Afghanistan, 60 per cent are women. Interestingly, 98 per cent of women who borrowed microcredit and set-up their own small business reported that they earned more respect in their households and communities, including that their opinion was more respected in the family.

32 The report documents the murder, threats and attacks against women who worked in high profile areas, or were otherwise considered to be working in professions that were not suitable for women. Female parliamentarians, provincial council workers, civil servants, journalists and women working for international organisations were targeted by a range of government and non-government actors, including traditional power holders, communities, government officials and armed groups.
mothers and fathers at the household level on child health. Below, we will explore further the relevance of mothers’ and fathers’ decision-making to child mortality in Afghanistan.
10. Mothers’ and fathers’ education and children’s health

There has been a significant amount of research examining how education levels of parents affect child health and child mortality. Most research has focused on mothers, but in this area there is also some limited research on fathers that has found that the role of fathers is significant and does impact child health. In this context, it is useful to look at the findings to understand better the roles of fathers and mothers in child health and to substantiate the argument that further research on the role of fathers in child health is needed.

The studies show that although there have been found to be differences between the parenting of fathers and mothers, both men and women play multidimensional roles in child health and well-being. The impact of a mother’s education on child health has been well researched and it has been found that there is a link between mothers’ educational level and child health, and that education levels impact mothers’ decisions and autonomy in relation to decision-making on child health.

10.1 Mothers

A mother’s level of education is a critical indicator for child survival. As Chen and Li (2006, p. 9) state, if a mother has education, it has a positive impact on child health. It also has a direct impact on child survival rates of children (Hobcraft, 1993, p. 159). It has even been argued that a small increase in mothers’ education can improve child survival (Hobcraft, McDonald & Rutstein 1984). A study in Bangladesh found that if mothers had a secondary or higher education, then their children’s chances of survival were 40 per cent higher than children of mothers who didn’t attend school (Mushtaque, et al 2003, p. 197).

Research has shown that for a range of reasons, a mother’s education has a positive impact on child health. It has been argued that if mothers are educated, it is not just beneficial to their child’s health; it will also have a positive impact on the education levels of their children, particularly their daughters (Desai & Potter 2008, p. 367). Educated mothers improve nutrition and health decisions for their children by their greater role in household decision-making (Caldwell, 1999, cited in World Bank 2005a, p. 69; Desai & Potter 2008, p. 367). A mother who understands and has knowledge of basic nutrition, health promoting child caring practices, health
problems and treatments will have a better chance of raising healthy children (World Bank 2005a, p. 69).

An educated mother is also more likely to look after her own health and thereby improve child mortality statistics. In Nepal, research found that educated mothers with secondary school education were more likely to receive tetanus vaccines and to deliver their babies at health care centres, compared to uneducated mothers (Shakya & McMurray, 2001, pp. 88-100). As we saw above, this will increase the likelihood that both mother and child will survive.

A significant University of Washington study that ranged over a 55 year period (1953-2008) and used data from surveys and censuses from 915 sources, confirmed the findings outlined above. According to Murray:

*Better-educated women are more likely to understand disease-prevention measures such as vaccines and mosquito nets, and to use them. They are more likely to take a sick child to a clinic early and to follow treatment instructions. They are more likely to understand germ theory and set clean water and sanitation as household priorities. With more schooling, women tend to have fewer children and space births more widely, both of which also reduce child mortality.* (Brown, 2010, p. 1)

In Afghanistan, a study by Mashal and Takona (2008) in Kabul found that a lack of education of mothers showed a negative association with child health. In particular, mothers with no formal education, regardless of other factors, were significantly more likely to have children suffering from diarrhoea.

10.2 Fathers

Other research has focused on the impact of both parents, education on child mortality and health and again has found there to be a positive correlation between education and child health. A gain in education for both sexes in countries such as Brazil, China, Indonesia and Mexico had a huge impact on the reduction of child mortality (Brown, 2010). Research in Africa illustrated that, even though child mortality is high in Africa at 200 deaths per 1000 births, child mortality was significantly lower among literate families, particularly in families where both the
father and mother had education, compared to children with illiterate parents. This finding was found to apply even during famine periods in Africa (Kiros & Hogan 2001, p. 450). Studies by Semba et al. (2008, p. 325) in Indonesia and Bangladesh also confirmed the importance of mothers’ and fathers’ education in child health through a study focusing on their levels of formal education and the prevalence of stunting. It found that increased levels of mothers’ and fathers’ education reduced stunting in their children, measured through their height and weight. In Indonesia it has been found that mothers’ and fathers’ education is equally important in reducing child mortality (Breievrova & Duflo, 2002, cited in Aslam & Kingdon, 2010, p. 3).

Despite the traditional image of fathers being seen as a distant authority and breadwinner (Ball & Wahedi, 2010), studies do indicate that a father’s education and his involvement in child health is also important and does have a direct impact on child health (Ball & Moselle, 2007, p.3) and perhaps particularly so in certain contexts that may be relevant to Afghanistan.

Some research on a number of developing countries has found that a father’s education level is a significant determinant of child health, more so than a mother’s education level. In Bangladesh, it was found that a father’s education level had a closer correlation to child stunting than a mother’s education level (Semba, et al. 2008, p. 325). Other research in Bangladesh found that if a father was educated, it reduced the risk of child mortality by around 40 per cent, compared to fathers who were not educated (Jamal Uddin, Hossain & Ohid Ullah, 2009, p. 275). Similarly, research in low income areas of Istanbul found that a father’s education level was much more important in predicting child mortality levels, compared to the mother’s level of education (Gyrsoy 1994, p. 183). Moreover, research indicates that a father’s level of education is an indicator not only of under five-year old child mortality, but also of mortality of infants up to the age of one year-old. A study in 1982 by Toros and Kulu in Turkey found that father’s education stood out as one of the most important factors for determining infant survival. Fathers who did not have primary school education had infants that were 1.6 times more likely to die within the first year of life, compared to fathers who had finished at least primary school (Toros & Kulu, 1982, cited in Gyrsoy 1994, pp. 183- 184).
Studies in Pakistan found that while a mother’s education was positively associated with the height and weight of the children, a father’s education was important for health seeking behaviours, such as immunisation (Aslam & Kingdon 2010, p. 26).

Research indicates that the correlations between parental education and child health are not universal and differ between countries. For example, in Latin America mother’s education was found to be a more significant determinant of child health, while in some Asian and Islamic countries, the father’s education levels were more relevant (Gyrsoy, 1994, p. 183).

Aslam and Kindon (2010, pp. 2-3) explore further the interrelationship between fathers’ and mothers’ education. After reviewing a number of studies, they also found that results differed in different countries. In Indonesia, for example, a study found that both mother’s and father’s education was important in reducing child mortality. In Bangladesh, however, as referred to above, it was found that a father’s education was a more reliable indicator of child stunting than a mother’s education.

Chen and Li (2006, p. 12) argue that father’s education is a stronger determinant of child health in some developing countries where fathers have a higher level of education in general than mothers. This also links to the fact that fathers will usually have a stronger role in decision-making in the household, where their higher levels of education reflect a higher social status in general (Semba et al., 2008, p. 326).

There is also evidence that mothers and fathers play different roles in promoting child health in the household. Fathers appear to play a more prominent role in ‘one-off’ decisions, such as immunisations and travel to health clinics, while mothers appear to be more involved in day-to-day decisions that relate to hygiene and nutrition (Semba et al., 2008, p. 327).

From the above evidence, we could argue that fathers’ and mothers’ education levels both have positive impacts on children’s health. It may be that the types of impacts are different, with the father’s education possibly being associated with health seeking decisions, such as getting immunisations and seeking medical assistance, and a mother’s with day-to-day child health issues, such as nutrition and cleanliness. There are some indications that father’s education is particularly important in countries where most of the population is Muslim, for the most part in Asia, and countries where the level of mothers’ education is low, along with a low social
status. This makes the issue of fathers’ role in child health particularly relevant for Afghanistan.
11. Conclusion

In the context of low levels of qualitative research on child mortality in Afghanistan and the failure to significantly reduce child mortality, it is important to ensure that programming to reduce child mortality is based on the reality of the situation in the country and is informed by objective information. The main objective of this research project was to show that the role of fathers in affecting child health is significant and should not be overlooked. This was done through providing information about fathers’ perception of their children’s health in Bibi Mahru area. The information collected was used to examine the link between fathers’ involvement in child health issues and child mortality in Afghanistan.

The findings indicated that the fathers interviewed are concerned about their children’s health and especially their children’s deaths. The fathers recognised a number of relevant threats to their children’s health. At the same time, irrespective of formal education levels many were not able to adequately assess the appropriate responses to protect their children’s health. Although global research indicates a strong link between parents’ education levels and child health, the research for this research paper did not establish this link. This cannot be taken as evidence against the global findings, since the sample was too small and in addition, although many fathers had formal education, more questioning would have been needed to examine the quality of the education received.

Globally, the low status and education of women has been found to affect child mortality rates and evidence suggests that this is also the case in Afghanistan (Mashal & Takona, 2008). The usual response to such a situation is to develop programming to improve women’s status and education levels, and to involve them in child health programmes.

However, research has found that fathers’ play a significant role in affecting child health outcomes, particularly in countries where women’s status and education levels are lower than men. These findings are highly relevant to Afghanistan, as a country with low levels of female education and status. In Afghanistan, at a minimum, fathers are involved with seeking medical care for their children, since women are often restricted to the home. Some research in Afghanistan has also indicated that most of the household decisions are made by men, including on child health related
issues. Interviews with fathers in Bebe Mehroo also indicated that fathers played a significant role in child health. The fathers did the shopping and therefore determined the diet of the family, responded to child illnesses through decision-making and taking children to doctors and hospitals. They were involved and cared about their children’s health and therefore it seemed that if they were further capacitated, they could play an even more productive role in protecting their children’s health.

In the similar cultural, physical and socio-economic environment of a squatter settlement in Pakistan, Jahn and Aslam’s findings showed that father’s perceptions of child health were very similar to those in Bebe Mehroo. They found that fathers were important “second-line caretakers and key persons in decision-making on child health issues” (Jahn & Aslam, 1995, p.204). As in this paper, they also concluded that fathers should not be excluded from health care initiatives. “This may be true for most societies; it is all the more true for the religious and socio-cultural environment found in Orangi, where fathers’ involvement in child care is related to the tradition of purdah [system of sex segregation] and the resulting paternal task allocations” (Jahn & Aslam, 1995, p. 204).

The current approach to child health, as reflected in the policies of the Afghan Government and the international community, has failed to achieve its aims to reduce child mortality and appears not to have responded to local needs. Therefore, it would be important to increase the amount of qualitative research on child mortality and to include an examination of the role of fathers to determine more accurately how their role impacts on child health. This could help in the design of more relevant and appropriate programming to reduce child mortality in the country. The findings in this initial survey, although only exploratory, suggest that it is worth exploring an increased involvement of fathers in child health initiatives in an effort to make child mortality reduction programmes more effective.
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Annex 1: Photographs of Bibi Mahru, July 2011

Public hand water pump for residents in Bibi Mahru.
Street with canal in Bibi Mahru
Residential street with drainage from houses into the gutter visible in Bibi Mahru.

Shops in Bibi Mahru.
Fruit and vegetable shops in Bibi Mahru.
Annex 2:

In the original design of the methodology for this thesis, the researcher designed a questionnaire for interviewing fathers. However, the researcher found that in practice he did not use the questionnaire format, but rather allowed fathers to speak freely on the topic of child health and then prompted fathers to address specific topics, as outlined in the checklist below. The topic areas are the same as those that were originally covered in the questionnaire format.

Research Checklist

1. Age

2. Marital status

3. Ethnic group

4. Number of children

5. Sex and age of children

6. Education level of husband, wife, children

7. Employment of husband, wife.

8. Monthly income

9. Working hours

10. Time spent commuting to work

11. Husband’s forms of participation in the household (cooking, washing, child care, cleaning etc.)

12. Father’s understanding of threats to family health
13. Forms of medical treatment sought for wife, for children, for infants

14. View costs of medical treatment

15. Trust in medical systems

16. Autonomy of wife in seeking health care

17. Children born at home or hospital

18. Health of wife during pregnancy

19. Number of children deceased and reasons for death

20. Efforts undertaken to prevent sickness in the family